# THE CANADIAN HOSPITAL

OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

MARCH, 1944


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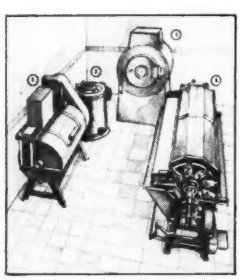

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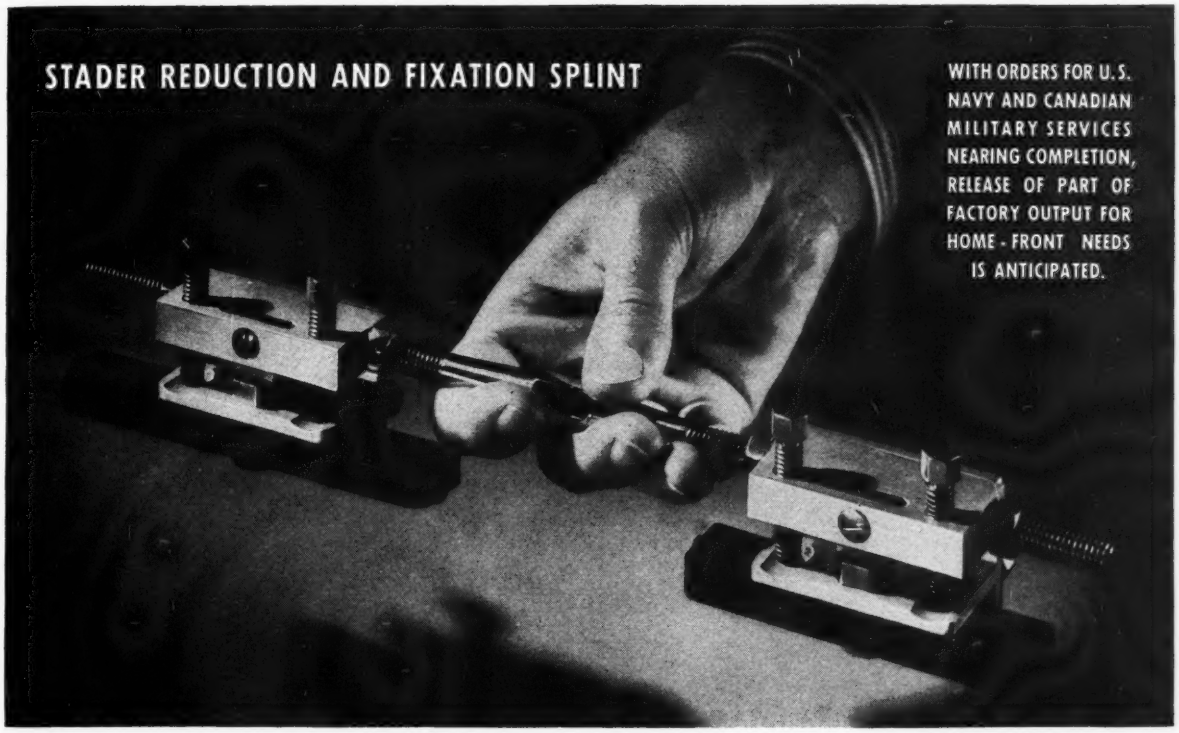


***To surgeons everywhere,*** and especially to many who have been inquiring about the Stader Splint—where they might obtain it and when—we are pleased to submit this note of optimism, which at the moment seems justified.

During the many months when the factory's entire output of Stader Splints has been required to meet scheduled deliveries to the Military services, obviously it was impossible to provide for civilian needs. And the patience of those who have been kept waiting is duly appreciated. Now we have reason to believe that home-front requirements can soon be partially satisfied.

The selection of the General Electric X-Ray Corporation as sole distributor of the Stader Splint assures hospitals, clinics, and surgeons of a convenient source of supply, since G-E's direct branches and regional service depots are readily accessible everywhere.

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# Contents

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CCAB

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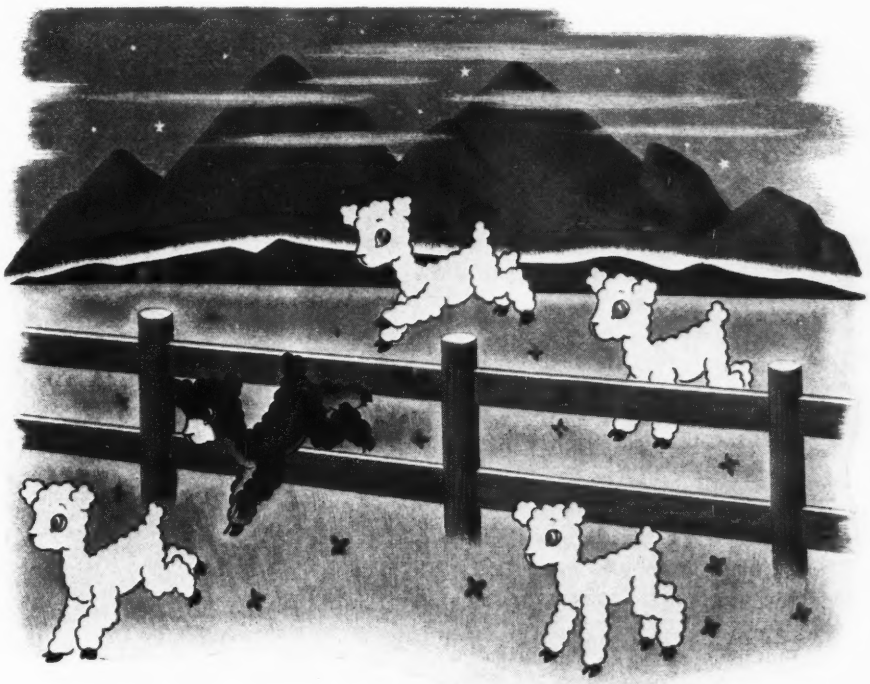
# *Communion with Morpheus*



For sure-fire nighttime sedation, sheep counting isn't always dependable even though a black one is brought in now and then for variety. Sick people, particularly, like a more positive means of getting a night's sleep.

Physicians who order a bedtime dose of 'Seconal Sodium' (Sodium Propyl-methyl-carbinyl Allyl Barbiturate, Lilly), 1½ grains, for restlessness know that they are likely to find a grateful and perhaps more cheerful patient when morning rounds are made. 'Seconal Sodium' exerts its effect so quickly that little time is available for sheep counting, even if the patient is so inclined. 'Seconal Sodium' is available in practically every hospital pharmacy or drug room in quantities adequate to prescription demand.

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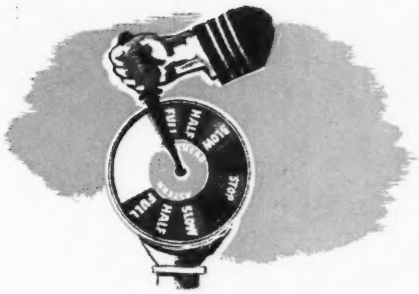


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# *Across the Desk*

**By C. A. E.**

### Slips Can Be Embarrassing

THERE are welcomes and welcomes—and quite novel was the one accorded the Honourable Dr. R. P. Vivian, Minister of Health for Ontario, on his arrival at the General and Marine Hospital, Collingwood, a short time ago. As he proceeded through the main entrance he stumbled a second, but as the reception committee had left the foyer for a moment he thought no one had noticed. Not so, however. One of the lady directors of the hospital, coming down the corridor, mistook him for another doctor and called to him, "Come there, pick up your feet!", which he did. Needless to say the lady director's embarrassment reached an all-time high when she realized that she had given the Provincial Minister of Health such a casual welcome. However, relating the incident at the Progress Club meeting later in the evening, Dr. Vivian claimed that even doctors have to be brought down a peg or two now and then, and that this incident had provided his "peg" for the day.

* * *

### Storage Space Again

Since we published a paragraph on the inadequacy of hospital storage facilities in our January column, we were interested to read in the February issue of Modern Hospital the results of a survey on the storage of supplies. Alida M. Jacobson of Bellin Memorial Hospital, Green Bay, Wis., reported that "No thought was given to storerooms when the hospital building was planned. Our only good storeroom had to be converted into a diet kitchen some years ago". Many other hospitals included in the survey have had to exercise considerable ingenuity in order to find space to accommodate increased inventories.

* * *

### "Big Ben" Cost $110,000

Big Ben, the clock of the Houses of Parliament at Westminster, is one of the world's most dependable timekeepers. It cost more than $110,000 and has been running since 1860.

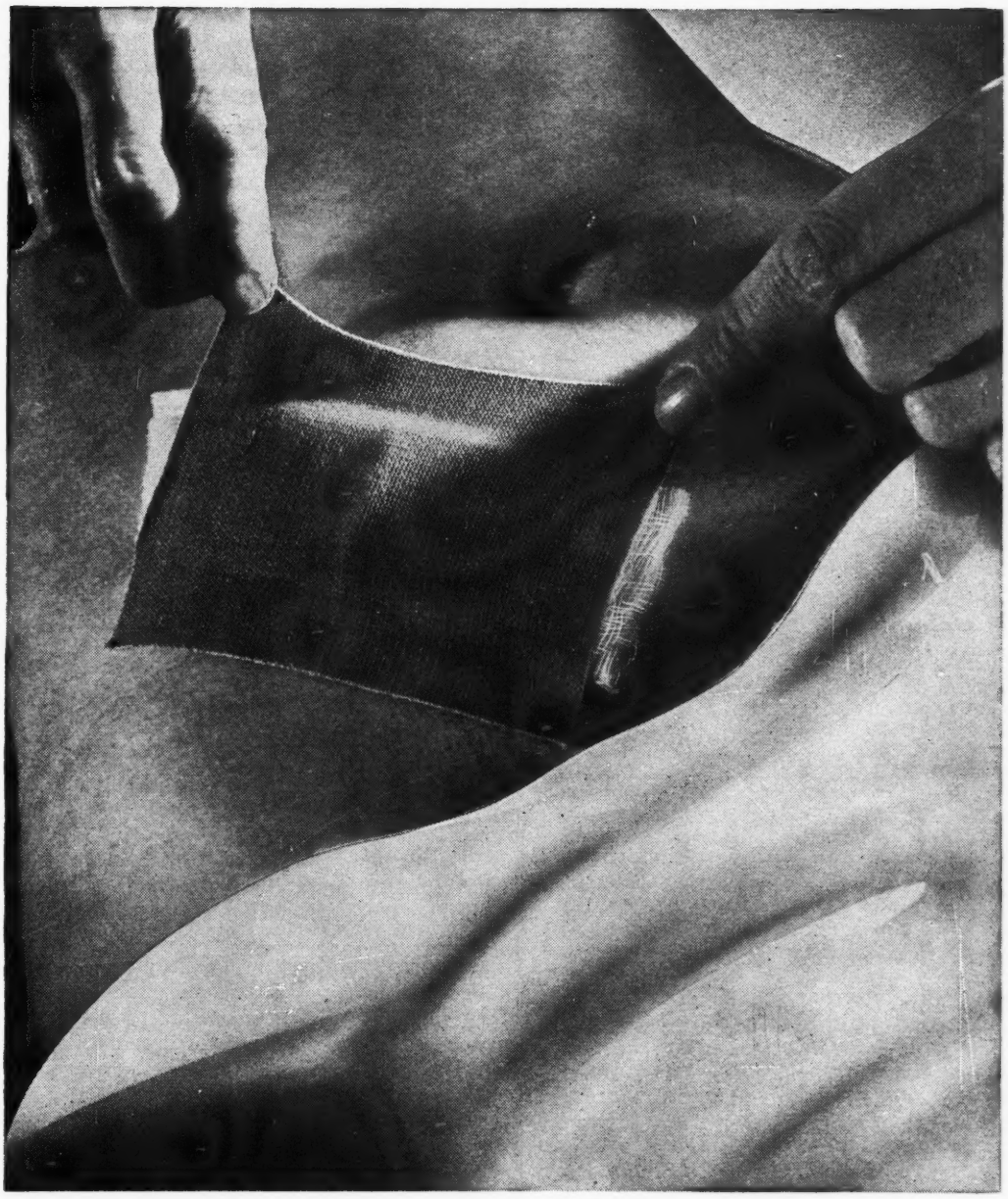
Our encyclopedia records that, since 1700, there has been no material change in the principles on which clocks are made, except in the substitution of steel springs for weights and, in the finer movements, the addition of the hair spring to regulate still further the action of the escapement or pendulum.

* * *

### Stader Splints Soon Available

Surgeons will be glad to learn that Stader Reduction and Fixation Splints may soon be available for civilian needs.

The General Electric X-Ray Corporation are the sole distributors of Stader Splints and for many months their factory's entire output has been required by the armed services. Now they report that, in all proba-



## POST-OPERATIVE DRESSINGS

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bility, home front requirements can before long be at least partially satisfied.

* * *

**Major "Dave" Bell Returns to Grimsby**

Major D. T. Bell of the R.C.A.M.C., has returned to The Metal Craft Company Limited at Grimsby, Ontario, after serving for the past two years at National Defence Headquarters in Ottawa.

Major Bell's duties covered the purchase and supply of all medical equipment for all the Armed Forces at home and overseas; the establishment of new modern military hospitals to take care of the increased need. His experience in manufacturing and his wide knowledge of civilian hospital requirements proved most valuable in this work.

* * *

**Recovers from Typhus**

The news has come by cable that Dr. Gordon Agnew, of West China, has successfully passed the crisis of typhus fever.

Dr. Agnew returned to China two years ago after having spent a six months' furlough in Canada. With him he had transported eight tons of medical and dental supplies, partly for his own clinic in Chengtu and partly for others in the same area. This large consignment of supplies was the gift of the Medical and Surgical Relief Committee of America, with headquarters in New York.

The problems Dr. Agnew experienced in having these supplies delivered safely can well be imagined, but the project was in the end successful. Dr. Gordon Agnew is, of course, a brother of our own Dr. Harvey Agnew.

* * *

**Is This Justice?**

An attractive young lady was motoring along the Driveway in Ottawa when she noticed a handsome young Air Force man whose attitude suggested that he might not be adverse to accepting a lift. The offer, made on the spur of the moment, was accepted. A very beautiful friendship blossomed, but apparently the father of the girl was not entirely convinced of the sincerity of the young man for, after all, the affair had started from a "pick-up". So one evening he had a few minutes alone with the lad. "Now, look here, my boy," he said, "before this goes any further, I want to know whether your intentions are honourable or dishonourable".

"Oh I say, sir," replied the boy who happened to be English, "Is there a choice?"

**Chief of R.C.N. Nursing Service**

*Photo by John S. Steele.*

The first nurse to serve as matron-in-chief of the R.C.N. Nursing Service is Marjorie Gordon Russell. Born in India and educated in Northern Ireland, Miss Russell is a graduate of the School of Nursing of the Hospital for Sick Children, Toronto. She has held responsible administrative and supervisory positions in her own hospital and the Montreal General Hospital.

* * *

**Dalén Invented the AGA Cooker**

From the Reader's Digest we glean some very interesting information on the life of Gustaf Dalén, the noted Swedish inventor. One of the most renowned scientists of modern times, Dalén had his lighter moments. The contraption he rigged up to awaken him in the morning, with its clock to rotate a spool, to ignite a match, to pull levers, to light an oil lamp, to start the alarm and so on and on was undoubtedly much more practical than any gadget Rube Goldberg has since devised for the amusement of his readers.

Of particular interest to hospital people, however, is his invention of the AGA stove which is now well known in the institutional field. With an AGA Cooker it is possible to estimate fuel costs almost to a dollar, for a year ahead. Burning 24 hours a day, heat is available constantly, and the coal consumption is almost unbelievably low.

As the result of an explosion of an acetylene accumulator Dalén was blinded in 1912. In time he was again able to employ his inventive genius and mechanical skill and he carried on successfully until his passing in 1937.

* * *

**Collection of Hospital Accounts**

Financial Collection Agencies, the largest organization of its kind in the Dominion, has been rendering to institutions, businesses and professional men a highly specialized collection service for the past eighteen years. For many years they have specialized in the collection of hospital accounts and in the guilding of their hospital clients with their collection difficulties. They have divisional offices at Toronto, Hamilton, Winnipeg and Montreal, and have affiliates and agents throughout the country. This firm is one of our new advertisers in the Canadian Hospital.

* * *

**Hairdressers' Sign**

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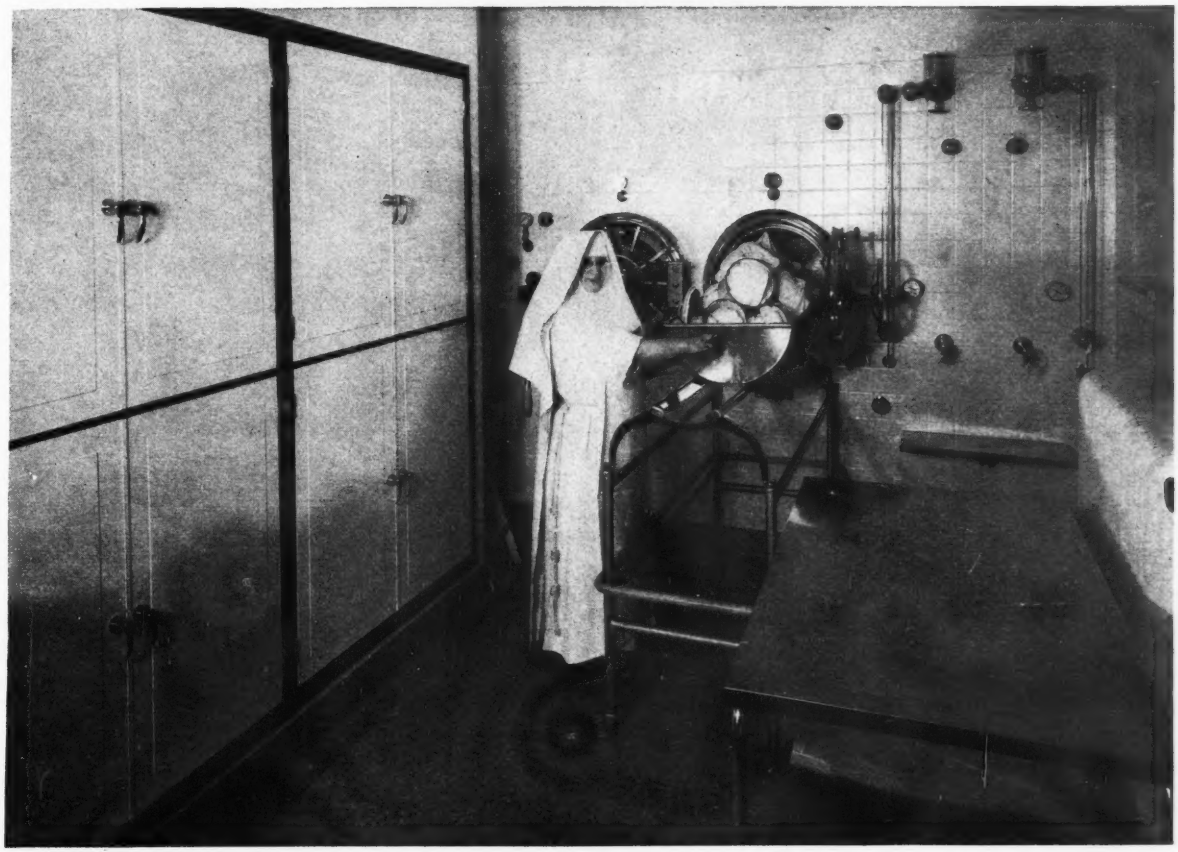
FOR ALL DEPARTMENTS OF THE HOSPITAL . . .

# AUTOCLAVES



*Scanlan-Morris Autoclaves installed in a modern central supply room.*

IN the maintenance of aseptic technique, the modern autoclave plays an important part. Its sturdy construction and all-round usefulness enable it to take over the major sterilizing load in the hospital and even do extra duty on frequent occasions. It sterilizes not only dressings and supplies, but also instruments, utensils, rubber gloves, solutions, and all the various items used in surgery, treatments, and in bedside care of the patient. Furthermore, it sterilizes more quickly and more dependably. It is easily controlled, permits of an exacting technique of sterilization with minimum supervision, is economical in operation. It saves extra equipment and extra help throughout the hospital—an accomplishment in these days of shortage of materials and personnel.

Catalog information on hospital sterilizers is available on request; also, a manual of planning and engineering data. A Handbook on Sterilization is offered to hospital workers, student nurses, etc., as a guide to sterilizing techniques and care of sterilizing apparatus.

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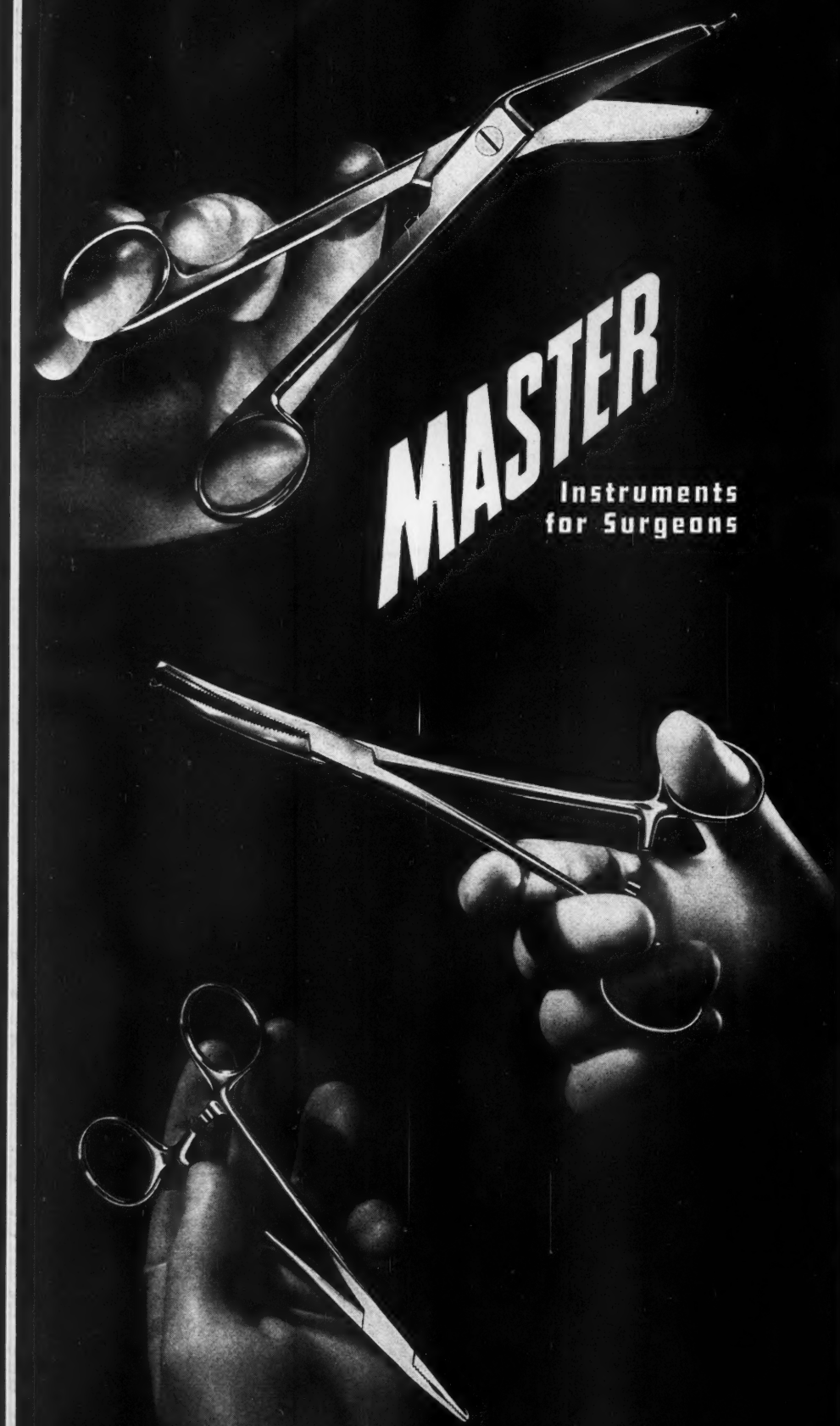


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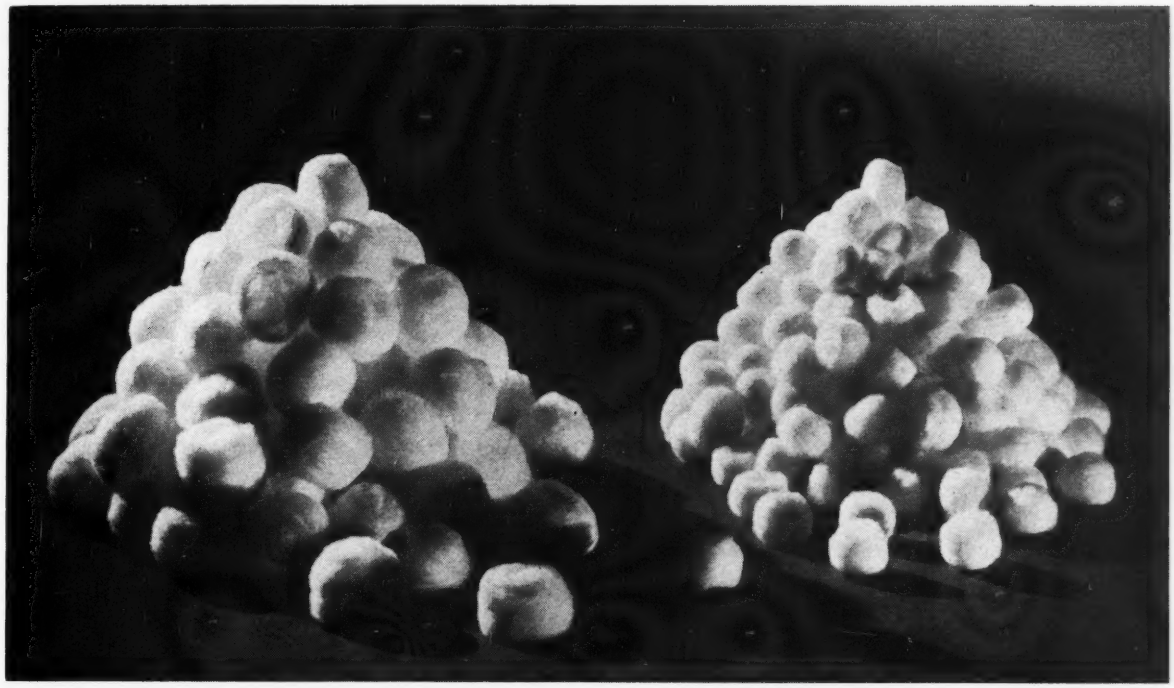

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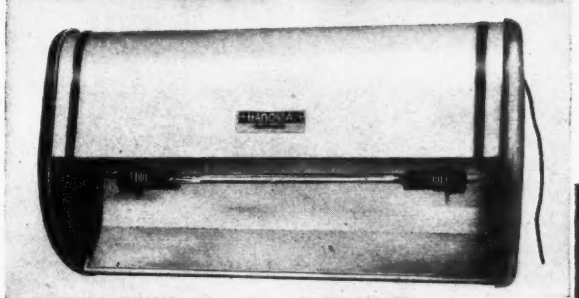

(2)

HERE is a lamp which is gaining increased popularity wherever installed. Hospital authorities speak highly of their effectiveness. The report on the findings by the Council on Physical Therapy says, "Clinical evidence submitted to the Council on Physical Therapy shows that under properly controlled conditions, ultra-violet radiation is effective in killing air-borne micro-organisms and may be used to supplement other measures for the prevention of cross infection in hospital wards, nurseries and in operating rooms for the reduction of air-borne infections in wounds".

The equipment is easy to install, simple and inexpensive to operate. Hanovia Safe-T-Aire Lamps are now being used with great success in Operating Rooms, Milk Formula Rooms, Nurseries, Clinics, Isolation Wards, Corridors and everywhere where air sanitation is an important factor.

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(3)

(1) Hanovia Safe-T-Aire Lamp in operating room.

(2) Hanovia Safe-T-Aire Filter Jacket Type Quartz Lamp.

(3) Hanovia Safe-T-Aire Lamp in Nursery.

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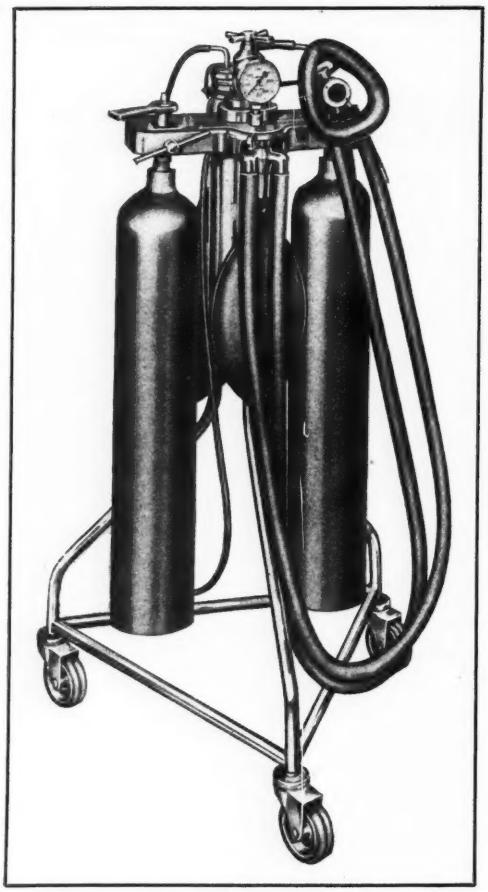

## The Emerson Resuscitator Inhalator and Aspirator

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**Whenever asphyxia strikes—in obstetrics, surgery or emergency—the Emerson Resuscitator proves invaluable.**

**With reduced staff and personnel, hospitals are more than ever dependent on this 3-purpose equipment when breathing failure is encountered.**

**RESUSCITATION**—The Emerson Resuscitator is an automatic, self-adjusting breathing machine for use in all cases where natural respiration has failed, causing asphyxia. It is equally effective in resuscitation of the new-born and in the treatment of respiratory failure in adults from shock, anesthetic accident, or post-operative collapse.

**ASPIRATION**—In addition to resuscitation, the Emerson Resuscitator - Aspirator - Inhalator combination may also be used for the aspiration of froth, mucous, or other secretions from the patient's throat.

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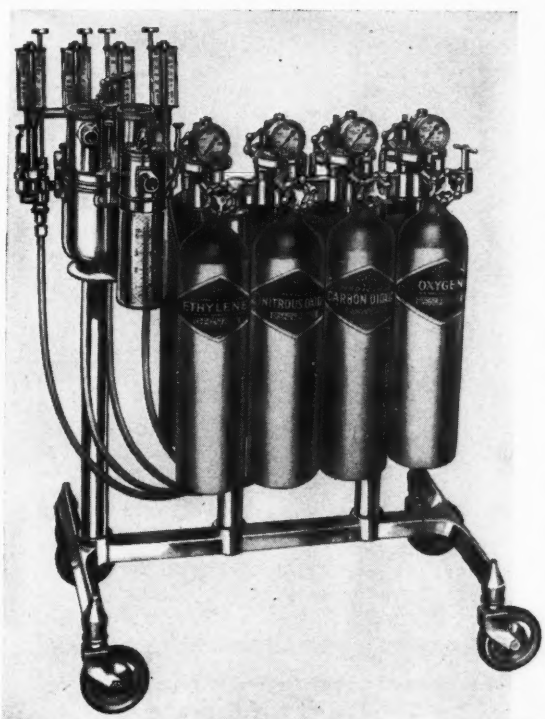


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For safety's sake, regulators, flowmeters, and tubing for each gas are associated by label and color in conformance with the standardized colors adopted for medical gases to preclude any error in the proper hook-up of the apparatus. Write for the Kinet-o-Meter brochure.

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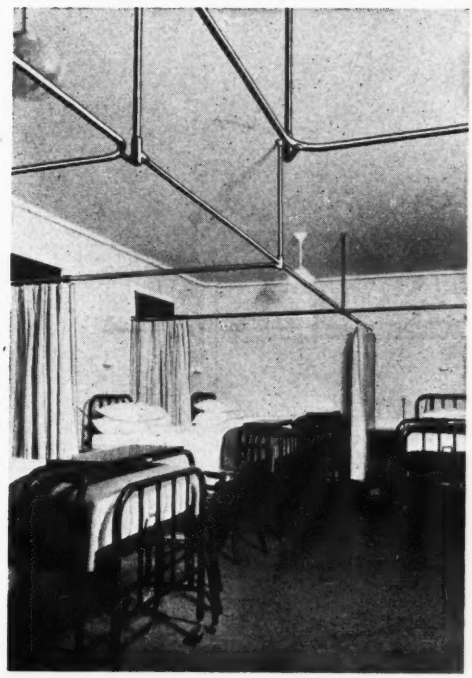
# STAN-STEEL *Hospital* EQUIPMENT



Ideal for all medical institutions, STAN-STEEL HOSPITAL EQUIPMENT is stronger, yet light and moveable due to the use of steel tubing wherever possible. Welded steel construction eliminates joints with consequent loosening and rattling. And there are no germ-catching or dirt-concealing crevices — easily kept pure and shining! We gladly answer enquiries. Write us today.

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**Though small in comparison to the sacrifices of these men, we are nevertheless proud to be filling one of Canada's vitally important war-time needs.**

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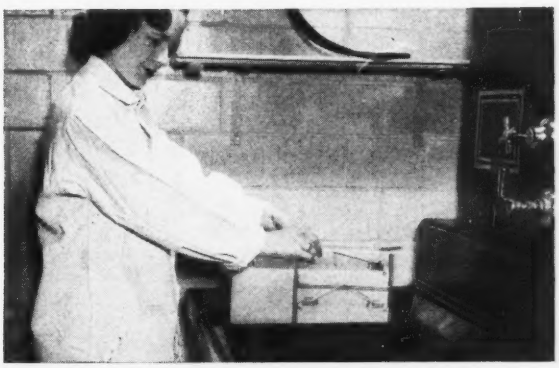
## TIMELY TIPS ON HANDLING FILM

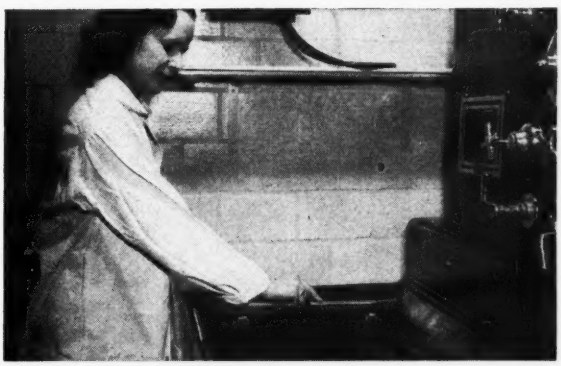
# Developing Procedure

● An x-ray film may be correctly exposed but unless proper developing procedure follows, the ultimate in radiographic quality will not be obtained. To produce the "perfect" radiograph requires the utmost care in all phases of technical procedure of which darkroom processing is the most important.

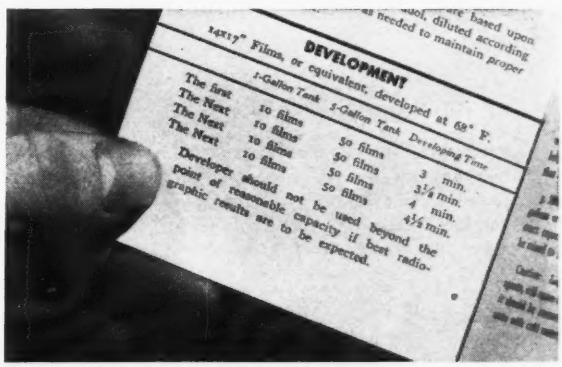
**1.** The developer should be stirred frequently—especially when the solution has been standing unused for any length of time. This provides uniform temperature and even distribution of the chemical contents throughout the tank.



**2.** Hangers should be immersed as rapidly and as smoothly as possible. Be careful, if hangers of different sizes are used together, to keep them separated to avoid scratched films.



**3.** Here in Binghamton, we agitate films for several seconds every 30 seconds to eliminate air bells and to secure uniform over-all action of developer. (Agitated and non-agitated films can differ as much as 100% in higher densities!)




**4.** Replace or replenish developing solutions as recommended by the manufacturer. It's poor economy to save on relatively inexpensive developing solutions by using them when exhausted. Doing this invites processing defects and spoilage of film.

For exceptionally good results, try Ansco's Liquadol Developer. It will develop *at least 50% more film* than ordinary powdered developers.

Ansco's improved fixer, Liquafix, contains a quick-acting agent which minimizes clearing time and will process approximately 30% more films.

Try them both soon. **Ansco of Canada Limited, Toronto, Ontario.**

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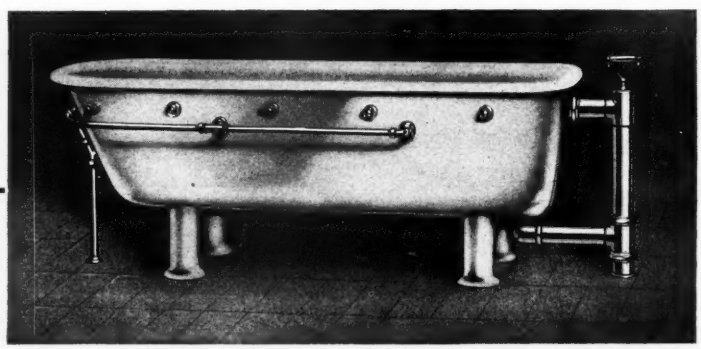
Available with or without fittings,—with or without buttons, drilled for five bells.

Or—with supply at end to floor and along sides, with or without buttons.

For all Crane hospital plumbing equipment, communicate with your Architect, Plumbing and Heating Contractor, or the Crane branch nearest you.



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Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, March, 1944 Vol. 21 No. 3

# Arrangements Effected for Hospital Care of Soldiers' Dependents

THE Dependents' Board of Trustees and the Canadian Hospital Council, after somewhat lengthy negotiations, have effected an agreement for the hospital care of soldiers' dependents. The Dependents' Board of Trustees, under the chairmanship of Mr. John Pembroke, Assistant Deputy Minister (Army), Department of National Defence, and well-known leader in welfare work in Montreal, was set up to provide assistance to the dependents of soldiers, where such was needed, in case of illness or other emergency. The Board has rendered considerable assistance to dependents in connection with their hospital accounts where these have been unusually heavy and beyond the personal resources of the dependent.

There has been, however, a widespread feeling in the hospital field that some modification of the regulations under which such assistance for hospital care has been given was in order. After a number of consultations and much correspondence the agreement here published was reached. The disposition of applications will be expedited; payments from the D.B.T. for less than the assessed amount of the account need not be accepted as payment in full; applications involving non-urgent or elective surgery may be considered in advance of hospitalization; and application forms may be kept on hand by the hospitals. This arrangement was to become effective on March 1st, 1944.

Although this agreement has been accepted by the Dependents' Board of Trustees and by the Executive Committee of the Canadian Hospital Council, the individual hospital is not bound to accept this arrangement. It has been the policy of the Canadian Hospital Council to endeavour to represent the hospitals on federal matters, and to formulate policies in general, but it has not considered that it has the power to commit the individual hospital either to expenditures or to financial restrictions. It would appear desirable, therefore, and may be necessary, that the individual hospital agree to these arrangements by some form of contract with the Dependents' Board of Trustees or its regional representative.

As we go to press these details have not been worked out. Nevertheless, it is suggested that hospitals conform to these arrangements until it be determined what further procedures, if any, are necessary to confirm this agreement. *(over)*

# Memorandum of Arrangements

**between**

**DEPENDENTS' BOARD OF TRUSTEES and the CANADIAN HOSPITAL COUNCIL**

**concerning the handling of hospital accounts of**

**DEPENDENTS OF MEMBERS OF THE ARMED FORCES**

1. The Board will not accept automatic liability for hospital accounts of dependents but will consider methods of facilitating the submission of applications for assistance by dependents who claim inability to meet hospital accounts.

2. The Board will furnish on request, to any hospital which is party to this arrangement, a supply of Form D.B.T. 1—Application for Assistance—for the use of qualified dependents. Applications for assistance will be accepted for consideration by the Board only if made voluntarily by such dependents; applications may not be made by the hospitals.

3. The Board will endeavour to give advance consideration to applications involving non-urgent or elective surgery, to the end that an indication may be given as to the likelihood of aid being granted by the Board and as to the extent of such aid, prior to the dependent's entry into hospital.

4. The Board will continue its present practice of investigating individually applications made by dependents and of determining as a result of such investigations if, or the extent to which, assistance will be granted.

5. The Board will endeavour to expedite the investigation of applications in which payment of hospital accounts is involved.

6. Hospitals will be free to render accounts to dependents on such bases as the hospitals may determine, but insofar as dealings between the hospitals and the Board are involved, the accounts will be deemed to have been rendered on the basis set out in paragraph 7 below.

7. For the purposes of the Board, an account rendered will be assessed on the basis of the rate charged to a public ward paying patient and that rate will include such services as are normally provided to an individual paying such public ward rate. Allowable extras not included in the rate normally charged to a public ward paying patient will be assessed on the basis of the D.P. & N.H. "Schedule of Fees, Medical Services and General Instructions" for such extras, provided that the regional Dependents' Advisory Committee on the advice of the District Chief Medical Officer of the Department of Pensions and National Health may recommend that such assessment be increased on any specific item of such extras where exceptional circumstances are deemed to warrant such action.

8. Where any payment is made by the Board but such payment is less than the full amount assessed as above, the hospital will be free to collect from the dependent the difference between the account as so assessed and the amount actually paid by the Board. However, if the dependent has requested and has been provided with private or semi-private ward accommodation, and the account has been assessed and any payment thereon, made by the Board in accordance with paragraph 7 hereof as though only public ward accommodation had been provided, the hospital will be free to make its own arrangements with the dependent in respect to the payment of any balance due because of such private or semi-private accommodation having been requested and provided, after allowing for any payments made by the Board.

9. If, as a result of agreement between the hospital and the Board, full settlement of an account is to be made and accepted in an amount less than that billed by the hospital to the patient, or if only partial payment of an account is to be made by the Board, payment will be made by the Board direct to the hospital with notification to the dependent only to the effect that the account has been settled in full, or that an adjustment has been made leaving $..... payable by the dependent.

Effective March 1st, 1944.

# R C N

# Hospitals Serve Our Growing Navy

By SURGEON CAPTAIN
**A. C. McCALLUM, O.B.E., V.D., M.D.,**
**Medical Director General,**
**Royal Canadian Navy**

AT the outbreak of the present war there were no naval hospitals or suitable naval buildings in which naval personnel could be treated. However, accommodation was available in military hospitals and those of the Department of Pensions and National Health. With the increasing tempo of the war, it soon became apparent that this accommodation would become inadequate for all the fighting forces, so early in 1941 plans were laid to create a chain of naval hospitals at all the larger naval bases.

Since Canada was showing a growing interest in her Navy, and a post-war Navy of considerable proportions was visualized, a very comprehensive plan of permanent naval structures was developed at the Halifax naval base. Among these permanent structures a naval hospital was authorized.

### Fine Hospital at Halifax

As the demand for hospital space was out-pacing the construction of permanent buildings, a temporary hospital to meet immediate needs was erected adjacent to the site to be occupied by the permanent hospital. This temporary hospital was planned and erected by the Naval Service, using ships' carpenters and other artisans on active service. This expedited matters to the extent that a hospital to accommodate 125 beds was completed within three months from its commencement. It provided four wards, each containing 30 beds, in addition to a few smaller rooms for isolation purposes, as well as laboratory, operating room, storage space, dining rooms and consultation rooms for various specialists.

While this building was in progress, plans were being drawn for the permanent structure which, of course, was erected by civilian contractors. This work was started in the summer of 1941 and completed in December, 1942. It is a reinforced concrete structure with brick facing and grey stone ornamentation. There is accommodation for 175 patients.

The building is constructed on a

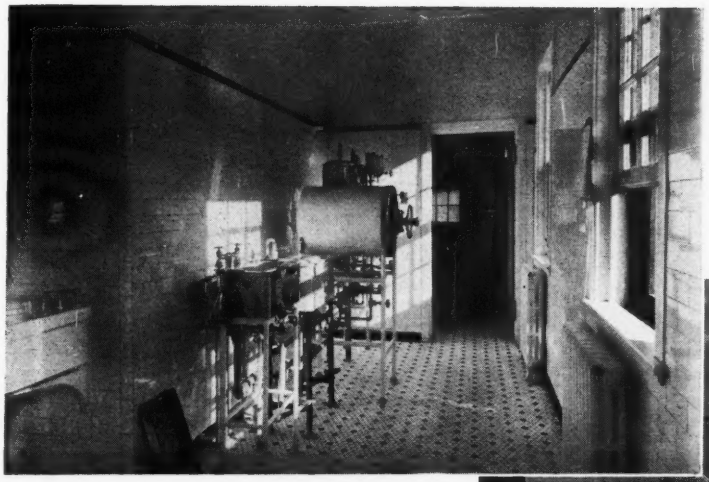
**R.C.N.H., Sydney, N.S.**

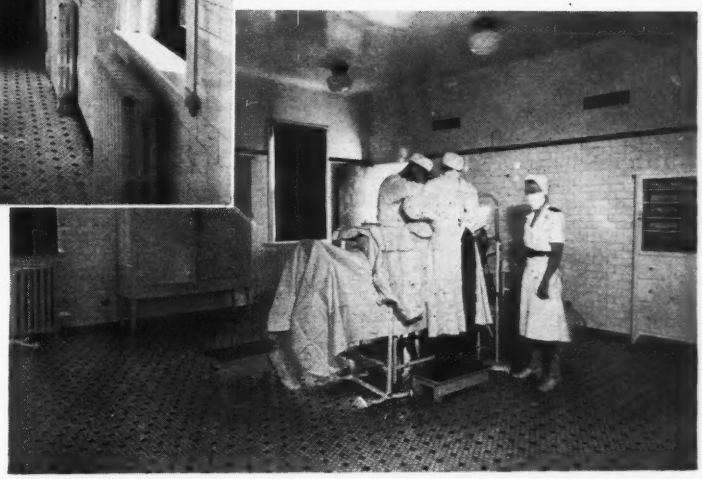
**Camp Hill Hospital,**
**Halifax, N.S.**

letter "H" pattern with sun rooms to both the front and back of the main wings. It is four storeys high, including the basement, in which are located the galleys, admitting rooms, x-ray department, lecture theatre, refrigeration for food supplies and—what is still more unique—refrigeration for garbage until disposed of in the incinerator. The benefits accruing from this method of garbage disposal are something that might well be considered by all hospital superintendents, inasmuch as the nuisance of flies and odours is practically eliminated.

On the first floor there are administrative offices and staff rooms for both Medical Officers and Nursing Sisters, as well as accommodation for 32 beds in each wing, including the sun rooms. On the second floor the plan of the wards is the same, but accommodation is provided in the connecting wing for single bed space, usually for seriously ill or officer personnel. On the third floor the layout of the connecting wing is the same as the second floor, but one wing accommodates the operating room suite, which consists of two modern major operating rooms, a fracture room, anaesthetic room, a large work room, battery of sterilizers, a scrub room and two separate rooms for use of Medical Officers and the nurses. One major operating room is provided with a glassed-in observers' gallery. Two elevators are provided, which are used to convey food trucks from the galley, as well as for passenger traffic. There is a plentiful supply of window space, providing excellent lighting to all wards and offices. The southern exposure of the hospital overlooks the harbour where the patients spend a good deal of time watching the coming and going of ships of war and the passage of convoys. All wards are divided by permanent partitions, bed-high, with plate glass above to the ceiling. This permits the placing of beds parallel to the walls rather

**R.C.N.H., Sydney, N.S.**





*Above: Sterilization room in the Naval Hospital at Sydney, N.S.*

*Right: The operating room in the same Hospital.*

than at right angles, which seems to provide a greater flexibility. Thus an increased number of beds can be installed when necessary.

Upon completion of the permanent hospital a covered ramp was built to connect with the original temporary hospital. This permitted expansion of the temporary hospital to provide increased laboratory facilities and extra consultation rooms. The combined space of the two buildings gives accommodation for approximately 400 patients.

Both temporary and permanent hospitals are wired for sound and, through the generosity of the R.C.N. Canteen, funds were provided to instal a master radio and individual ear phones. An international touch was added when the Maple Leaf Club of New York City provided the materials for the drapes in all sun rooms and private rooms.

**Esquimalt**

At the naval base at Esquimalt there was also a great dearth of hospital beds, and as there had been no permanent naval medical buildings, it was decided to erect what is commonly known in the naval service as a "Sick Bay", which implies that it is hardly large enough to be classified as a hospital. This building is of reinforced concrete and brick structure and contains 50 beds, with reasonably adequate administrative space, operating suite and other accessories, such as x-ray and physiotherapy departments, galley and storage space. In a relatively short time this accommodation was again found to be inadequate, and a temporary structure was built on to the permanent one, containing an additional 60 beds. This complete unit was located within the barracks grounds, which left little or no transportation problems.

**Other Construction**

With the growth of the Sydney base, another hospital was required. Since it was anticipated that this base would be a fairly active one in any postwar programme, a semi-permanent hospital was decided upon, inasmuch as materials for permanent structures were becoming more difficult to obtain and the necessity of speedy construction was paramount. A semi-permanent structure differs from a temporary one only in its more solid foundation, its better finish inside and asbestos shingle on the outside—the main frame-work, of course, being of wood. This hospital also contains all the necessary appointments of a complete hospital, the operating suite being quite spacious with a terrazzo flooring and tile walls to the ceiling. While this hospital was originally built to accommodate 150 beds, it is quite possible to put in a further 50 beds.

With the establishment of a large training centre at Deep Brook, Nova Scotia, another hospital became a necessity. By the time this magazine appears this hospital will be in use. It is of temporary, single-storey structure and contains 250 beds, with all the necessary equipment of a modern hospital.

As to the situation at St. John's, Newfoundland, the erection of buildings was primarily a concern of the Royal Navy; but slightly over two years ago a 250-bed hospital of temporary structure, very similar in layout to the hospitals at Deep Brook and Sydney, was erected by the Royal Navy but staffed by the Royal Canadian Navy. This was an exceedingly active hospital, on account

**Medical Ward, Sydney. Similar layout in other R.C.N. Hospitals.**

of the large number of ships based at that port and the U-boat activity in the Western Atlantic. In fact this hospital became so crowded that additional barracks space had to be used as an overflow. However, as barracks space is never adequate to good treatment, another 250-bed hospital, almost a duplicate of the first, is now under construction and will be ready for occupancy this summer. No doubt in postwar days these hospitals will fill a long-felt want among the civilian population of Newfoundland.

**Future Plans**

With the continued expansion of the naval service as the war progresses, still more hospitals will be required, and plans are laid to erect a new 150-bed hospital at Esquimalt, a 125-bed hospital at St. Hyacinthe, Quebec, for use of the Signal Training Establishment there, and a 100-bed hospital at Shelburne, Nova Scotia. These will all be of temporary structure, but will be well equipped and self-sufficient.

While there is a general assumption that all men on active service are picked from a healthy stratum of life and should require little or no hospitalization, yet a rather amazing variety of conditions can arise. In civilian life most people stay at home for the minor ailments and after a day or two in bed are ready to resume their occupation. Men on active service, however, cannot be left in their mess-decks or barracks space, but must be put to bed in hospital upon the slightest provocation. This, of course, means that they get very early treatment with a correspondingly early return to duty, thereby keeping the man-hours lost to a minimum. From the beginning of the war to the end of January, 1944, there have been one million hospital days in the Royal Canadian Navy, but it is gratifying to know that from a population which now numbers 80,000 there have been but 63 deaths from natural causes or non-enemy action in 53 months of warfare. Even the million hospital days mentioned represents but 2½ per cent of the days available for duty or training, or slightly less than 9½ days per man per annum, which is considered to be the normal expectancy of lost time in civilian industry—a very creditable record under wartime conditions.

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**STOP PRESS!**

## Revised Health Insurance Plan Presented to Commons Committee

As we go to press word is received that the revised draft of the National Health Insurance measure has been presented (March 1st) to the Parliamentary Committee on Social Security by the Honourable Ian Mackenzie.

Benefits will be very much as planned in the draft presented last year. They will include general practitioner service, specialist care, hospital care, nursing care and dental care up to 16 years of age. Apparently the same programme of assistance for preventive activities is included. The Bill is designed to cover all persons, including indigents.

A flat contribution of $12 a year for those able to pay must be paid by every person over 16. In addition single persons would pay 3 per cent of income over $660 (maximum $30) and married persons would pay 5 per cent of income over $1,200 (maximum $50). The employer's contribution has been deleted. No payments are to be made for children under 16 years.

The province is to collect the basic $12 fee for every adult. Besides the cost of administration and that for benefits to indigents, the provinces must make up whatever sum the benfits amount to above the estimated cost. It is anticipated that the annual total cost will be $250,000,000. It is not planned to exempt Christian Scientists or others from making a contribution, although no one will be obliged to accept the benefits of the Bill. There will be free choice of

*(Concluded on page 90)*

# Building Up
# A Voluntary Auxiliary Group
# ....*In Wartime*

**By MRS. ALTON GOLDBLOOM,**
**President, Women's Auxiliary,**
**Jewish General Hospital, Montreal.**

THE role of the voluntary auxiliary group in time of peace is a recognized and much appreciated aid to hospital welfare. In these war days, the organized voluntary workers are a ray of hope to harassed, depleted hospital staffs, faced with shortage of help in all departments and striving to maintain efficient service to the patient. How we have met the challenge, maintained our strength and expanded our usefulness is the subject of this brief report of our own experience.

Organized more than seven years ago, the Women's Auxiliary of the Jewish General Hospital has fostered an imposing complement of two thousand senior members. Of this number, well over two hundred form a distinctive group and are known as Patronesses to the Life-Saving Fund. The war has given impetus to their growth and the generosity of their support makes possible every life-saving measure for the indigent patient. When this was firmly established, we embarked on a course of interesting the various family age groups in hospital welfare. We enrolled infants and children up to sixteen years of age in a Nursery Fund membership. The funds derived from their support has made possible a substantial annual grant to the hospital for the needs of the non-paying new-borns. Last year we decided the time had come to fill the gap in membership between the Nursery Fund and the Senior Groups. Thereupon we organized the Women's Auxiliary Juniors, young unmarried women between the ages of sixteen and thirty, including wives of young men in the armed forces. Though their numerical strength is still under three hundred, they have already contributed two hundred and fifty dollars for the purchase of medical books for the hospital library, and have assumed this responsibility as their chief annual contribution.

*Address, Convention of Women's Hospital Aids Association of Ontario, Toronto, October 1943.*

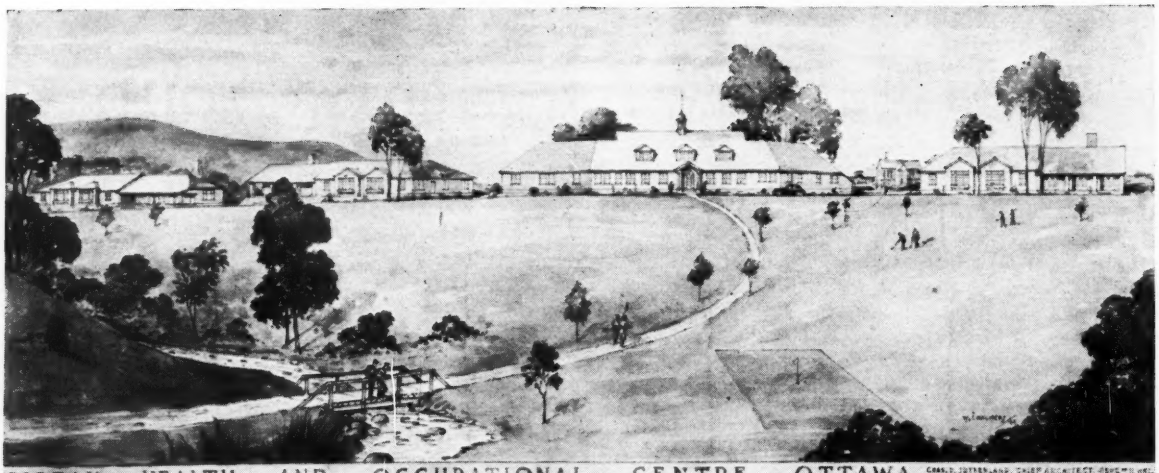
**Total Membership of 3,500**

Having devoted ourselves to the building of this large force for good, being a total membership of approximately three thousand five hundred, how have we met the annual task of collecting dues, despite the wartime lack of transportation? Dues are the foundation of our monetary assistance to the hospital, and we were thus faced with the finding of added ways and means of maintaining ourselves at full strength. Appeals were intensified for our members to send their dues to our financial secretary without waiting to be called upon; our programmes at meetings, where reception of dues is an established custom, were planned specifically to attract a larger attendance. But beyond all these measures, we planned as wisely as we could in the selection of the members of our Board. Electing on the premise that collection of dues was the first requisite of service expected, we made our choice according to the concentration of our membership by district, thus assuring ourselves adequate coverage.

While the foregoing was an essential problem to be solved, the urgency of the call for direct help to the hospital became apparent more than a year ago. Our hospital has a large farm adjoining its building, and has, since its inception, canned the surplus produce, thus furnishing itself with a yearly supply of fruit and vegetables at minimum cost. It soon became evident that unless our volunteers rallied to the need, the hospital would suffer for lack of supplies and the waste of farm products would be a serious misfortune. We did answer that call; and, thanks to the willing hearts and hands, we look with pride on a task well done.

Next came the realization that unless we organized our voluntary workers under efficient direction to assist in the wards, dining room and kitchen, the depleted nursing and kitchen staffs could not possibly cope with a hospital constantly filled to capacity. We thereupon established a Women's Auxiliary office in the hospital, installed our own telephone, and placed a paid secretary in charge. After due study we planned the service in three shifts daily, wherever and however our volunteers might be needed. Our volunteers were instructed to supply themselves with white long-sleeved dresses or coats, and the organization provided armbands designating "Volunteer Worker, Women's Auxiliary, Jewish General Hospital". As a further means of making the volunteer more hospital-conscious, we held a recent

*(Concluded on page 104)*




# Pensions Hospitals Being Expanded to Meet Anticipated War Needs

**By T. B. BAIN, M.D.,**

**Director of Medical Services, Dept. Pensions and National Health**

IN September, 1939, the Department was operating 2,720 beds in their own hospitals. In December, 1943, the Department was operating 7,405 beds.

In addition to this number we have a fairly large building programme either in actual process of construction or for which plans are in course of preparation. Three hundred beds at the Veterans' Pavilion of the Ottawa Civic Hospital are ready for immediate occupancy, and considerably more than half the number of the following additional hospital beds should be ready before this summer:

| | |
|---|---|
| Ottawa | 300 |
| London | 378 |
| Toronto | 450 |
| Saint John | 152 |
| | 1,280 beds |

Contracts have been let and construction has commenced for:

| | |
|---|---|
| Edmonton | 239 |
| Winnipeg | 432 |
| Ste. Anne de Bellevue | 264 |
| | 935 beds |

We have had approval in principle and plans are being prepared for:

| | |
|---|---|
| Vancouver | 540 |
| Regina | 186 |
| Toronto | 1,400 |
| Montreal | 300 |
| Halifax | 250 |
| Saint John | 60 |
| London | 43 |
| | 2,779 beds |

In addition to the foregoing, the Department is arranging to set up five Health and Occupational Centres across Canada. These are to take the place of what were previously thought of as convalescent hospitals. The points at which these are to be erected and the amount of accommodation is shown in the following:

| | |
|---|---|
| Ottawa | 200 |
| Ste. Anne's | 400 |
| Toronto | 400 |
| London | 200 |
| Vancouver | 200 |
| | 1,400 beds |

*Above: The first of the five proposed health and occupational centres to be set up by the Pensions Department will be the Rideau Centre, shown above in the architect's drawing. In the centre is the administration wing, which includes kitchen and dining room. Flanking it are some of the eight bungalows which will provide residence for 200 ex-service personnel. Each of the bungalows contains a common room and verandah, for use in the summer. The Canadian Red Cross has offered to construct on the property a building to house a gymnasium, pool and auditorium for floor games. Mechanical games are planned to develop the functions of partly-disabled men.*

*The proposed new veterans' hospital at Sunnybrook Park, in North Toronto. The above sketch by the architects, Messrs. Allward and Gouinlock, indicates the fine fire-proof, stone-trimmed brick buildings planned. The central building, 8 storeys in height, is the active treatment unit with 850 beds. Immediately to the right is a building which provides for 100 officers and women on the upper floor and the outpatient department on the lower floor. To the extreme right is the administration unit, with the pensions and pay departments.*

*The building immediately to the left of the central unit provides for 250 up-patients on the upper floors, with the necessary recreation rooms. This connects directly with the auditorium and chapel at the rear. The commissariat is on the lower floors, with direct access to all the buildings. On the extreme left is the residence for 250 nursing sisters.*

*In addition to the buildings shown, and located to the east (that is to the right of the group shown) will be the neuropsychiatric building for 150 patients, a 100-patient building for chest diseases, the orthopaedic building, the laundry and the power house. It is proposed that a Red Cross hostel will be located adjacent to the entrance to the property for the convenience of friends and relatives of the patients. These buildings will be located on the north side of a beautiful ravine, the buildings to face south. The present entrance to Sunnybrook Park will be moved further north, circumventing the hospital buildings.*

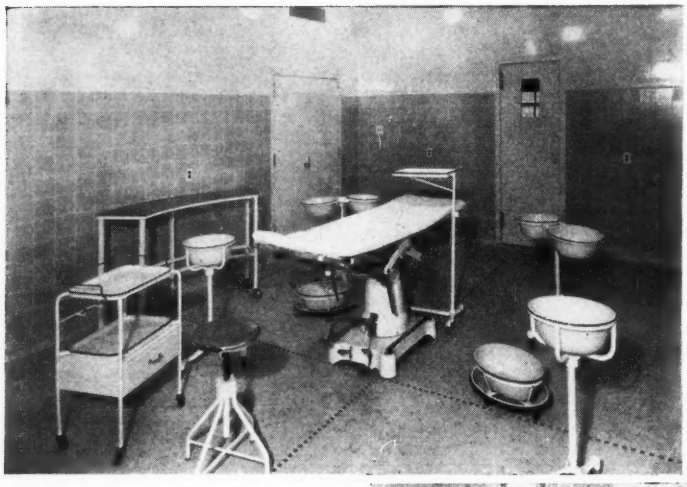
The following, therefore, is a recapitulation of the Departmental beds:

| | |
|---|---|
| Operating as of December 31, 1943 | 7,405 |
| Coming into operation, 1944 | 1,280 |
| Under contract for construction | 935 |
| Construction approved in principle | 2,779 |
| Health and Occupational Centres: | |
| Tenders being called for now | 200 |
| Approved in principle.. | 1,200 |
| Total..... | 13,799 |
| This space will, under emergency, accommodate in 1945 ..... | 15,000 |

If the bed accommodation at present being occupied by the three Medical Services of National Defence is added to the foregoing, it is anticipated that between 25,000 and 30,000 beds will be available for returning casualties.

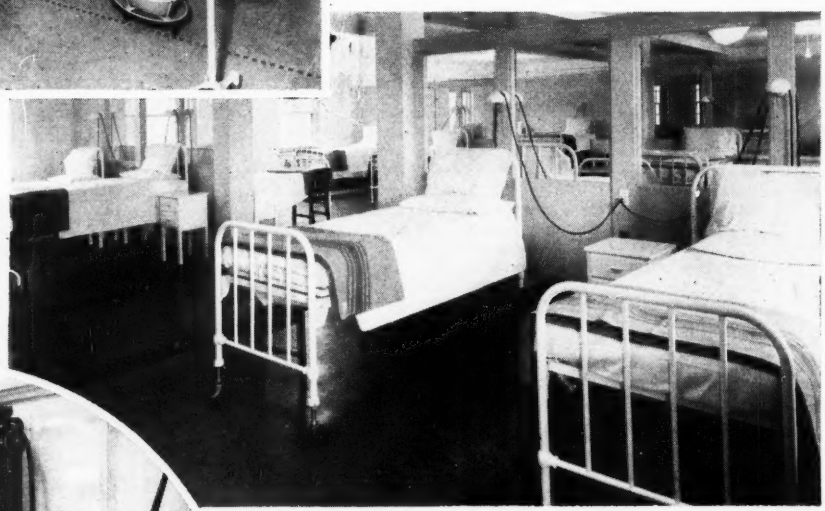
In assessing the number of beds likely to be required by this Department for the hospitalization of casualties all the known factors have been assembled. Though there are still many unknowns in the equation, still the Department feels that the number of beds coming into service should be adequate to meet its responsibilities in connection with treatment of these casualties.

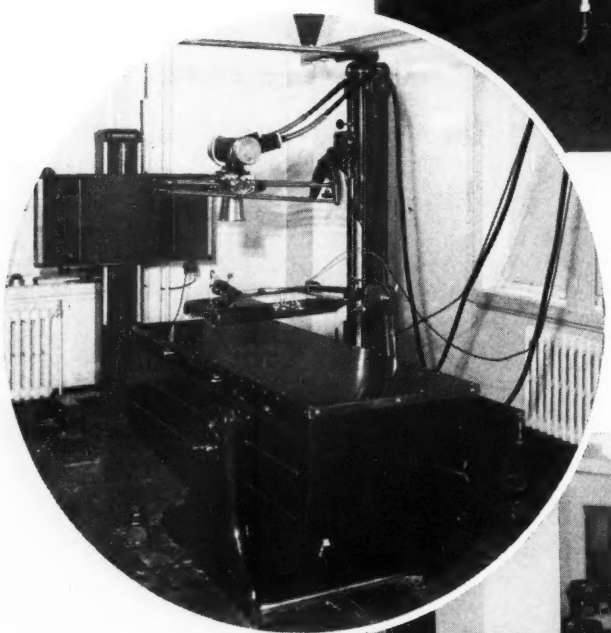
*Right: Exterior of the new 225-bed Colonel Belcher Hospital at Calgary.*



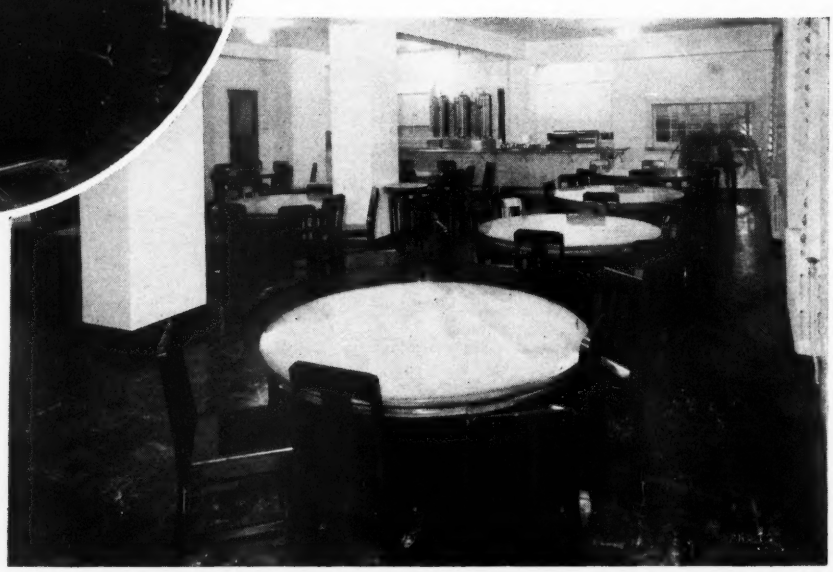
*Some views of the Colonel Belcher D.P.N.H. Hospital, Cangary.*

***Left: Operating Room.***
***Below: One of the wards.***





***Left: The X-ray room.***
***Below: The Dining room.***



# *Possible Effect of*

# HEALTH INSURANCE *on* HOSPITALS

By HARVEY AGNEW, M.D.

IT is premature to discuss in too specific a manner the likely nature of any health insurance measure in Canada. There is, however, sufficient evidence to make one feel that health insurance in some form or other is "on the way", and the general nature of the federal measure likely to be introduced at the present session is now known. It has been intimated that the present draft may undergo extensive revision before it becomes law, particularly with respect to financial clauses but, presuming that a measure substantially as now drafted may be passed and ultimately become operative in the provinces, it is reasonable to suppose that certain results affecting hospitals may be anticipated.

**1. Increased Accommodation Required**

A definite increase in demand for hospital beds may be anticipated. This will probably reach a peak in the early years of operation because of an accumulation of non-urgent surgical conditions. While this may ease off later on to some extent, there will probably be a permanently high level of occupancy, in view of the changing living conditions of our people and the steadily rising index of hospitalization in recent years, even without the benefit of hospital insurance. The amount of hospitalization will depend to some extent also upon the basis of payment for medical care.

Estimates vary as to the amount of additional accommodation likely to be required. If there be adequate provision made for chronic and incurable patients and for convalescents, the total increase in accommodation required may well amount to 25 or 30 per cent, if not more, of present facilities.

This does not mean that the general hospitals would need to expand to this extent. If adequate facilities for the chronic, the incurable and the convalescents be provided, there may be sufficient beds released in the general hospitals to meet the major portion, if not all, of the increased demand upon their services. However, in rural areas convalescent homes would have little patronage and too many hospitals for chronic patients might not be advisable. Therefore the increase in such areas may need to be in general hospitals.

**2. Indigent or Non-pay Patients**

If health insurance covers those individuals who cannot pay (and this is a fundamental necessity), the indigent or non-pay type of patient, except for occasional transients, will disappear. These patients will become paying patients and it is anticipated that hospitals will be paid approximately the cost of their care.

This may have several results. The large ward as we know it should disappear and will probably be replaced by smaller cubicle wards of 4, 6, or at most 8 beds. This arrangement would have the added advantage of permitting better segregation of clinical types. As hospitals will probably be paid the approximate cost of the care of these patients, these wards may be better furnished and be more in keeping with the present high standard for private wards. (See also Nos. 12 and 13.)

**3. Use of Volunteer Hospitals**

If health insurance rather than state medicine be developed, there is good reason to feel that the continued use of voluntary hospitals, lay or religious, will be maintained. The present draft of the federal measure specifically states that "arrangements shall be made only with (i) hospitals known as 'non-profit voluntary hospitals', (ii) municipal hospitals, (iii) provincial government hospitals, (iv) Dominion government hospitals, and that the said hospitals shall . . . . . be on an equal footing under the said arrangements"; moreover "any person for whom hospital services are ordered as aforesaid shall have the right of selection of the hospital from among the hospitals capable of providing the services required".

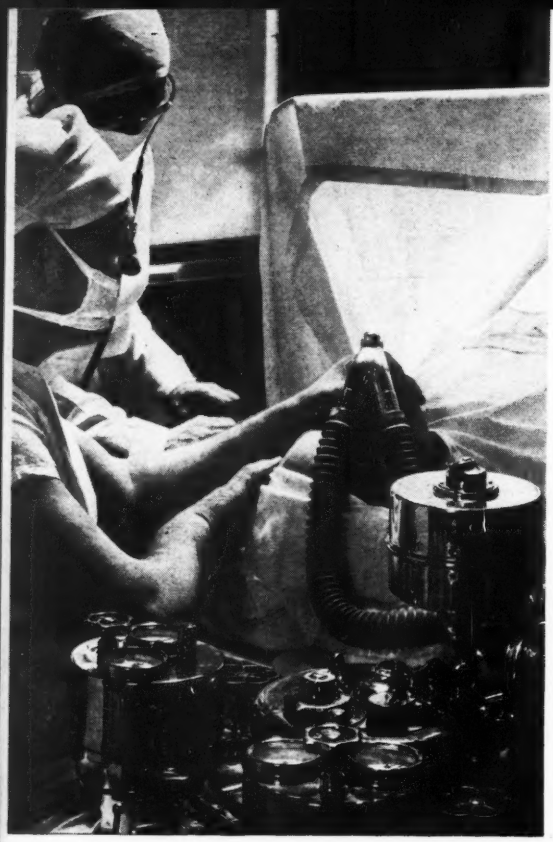
With some 85 per cent of our public hospital beds in voluntary hospitals, the likelihood of these hospitals not being freely utilized under health insurance is very slight. However, under a plan of state medicine, wherein the state would pay all costs and ultimately take over full control, it is quite possible that the complete displacement of the voluntary hospitals by state institutions which has taken place in Germany since 1883, would be repeated here.

**4. Outpatient Departments**

These will probably disappear as we now understand the term. If every person has the right of going to a private physician as a paying patient, the vast majority of former patrons of outpatient departments will probably elect to use a private physician. However, as adequate diagnostic facilities will likely be provided, it is reasonable to presume that diagnostic centres or clinics may be established in larger centres, to which practising physicians could send certain patients for diagnostic study. The logical place for such diagnostic units would be in the larger hospitals, because of the facilities and personnel already available, and it is reasonable to suppose that these might be housed in the former outpatient departments. The medical staff of such diagnostic units would probably be paid for their work.

*(Continued on page 82)*

*Adapted from an address given to several hospital associations in October 1943.*



# FATALITIES *IN* ANAESTHESIA

## *Part 1*
## *Volatile Agents*

**By HARRY J. SHIELDS, M.B.,**
**Chief Anaesthetist, Toronto General Hospital, and Head of the Department, University of Toronto.**

IN considering the hazards of anaesthesia it should be recognized that anaesthesia is an abnormal state and is not to be classed lightly as natural sleep. It must be admitted also that anaesthetics are harmful drugs, effecting undesirable changes in many of the body functions. The capacity of body tissues for utilizing oxygen is diminished. Untoward circulatory effects are frequent. In ether anaesthesia, generally considered the safest from the standpoint of the cardiovascular system, irregularities in heart action and changes in the conductive mechanism as shown on electrocardiographic studies, are quite common.

Some patients, too, will re-act in an abnormal fashion to anaesthetic agents, or they may be sensitive to them, as are many individuals to drugs of other natures. It is plain, therefore, that going to sleep under anaesthesia is not the same as going to sleep in bed. Patients requiring surgical intervention may be aged, anaemic, or handicapped by pathological conditions in various organs, or in other ways. When, therefore, there is added to all these hazards those associated directly with the operative measure, such as loss of blood and shock, it is apparent that even in the best of circumstances an occasional fatality might eventuate. It is obvious that if the management of the anaesthesia is imperfect disasters are much more probable. Care on the part of the anaesthetist, in even the most minor of operations, is therefore imperative.

*Photograph by Dr. Max Thorek, F.R.P.S., F.R.S.A.*

*Over-dosage Infrequent*

To those not too familiar with the administration of anaesthetics, a fatality pre-supposes direct overdosage. It may be taken for granted, of course, that should anaesthesia be pushed to the point at which respiration ceases, death will result quickly unless the anaesthetic is promptly withdrawn and resuscitative measures instituted. Resuscitation in ether anaesthesia under these conditions should not be difficult because the margin of safety—that is the time elapsing between cessation of respiration and that of heart action—is comfortably wide. Even in the case of the depressant anaesthetics such as chloroform and ethyl-chloride, in which the margin of safety is distinctly narrower, resuscitation should be successfully accomplished, provided that the proper measures are instituted with no delay.

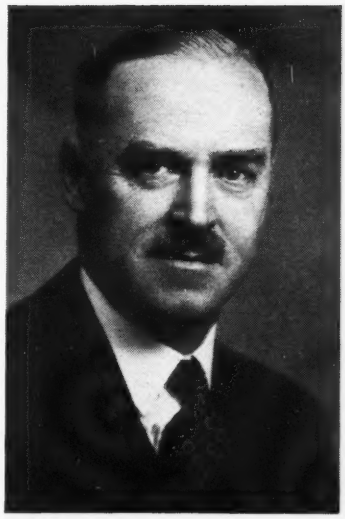
In the writer's opinion direct overdosage of the anaesthetic, except possibly in the case of the depressant agents, is a comparatively infrequent cause of death. Fatalities more commonly occur at lighter levels of anaesthesia and are due fundamentally to conditions of oxygen starvation in the various vital centres. The role of the anaesthetic in bringing about this state of affairs must not be overlooked. In many instances complications arising in the administration may be a decisive factor in determining a fatal outcome. A study of these complications is therefore pertinent.

Difficulties in the management of anaesthesia occur mainly at two dis-

tinct periods in the administration. In one group the troubles arise early. Those of us who have had experience with anaesthetics can recall instances, usually in the case of a vigorous male, an alcoholic or a highly sensitive person, in which the patient may do no more than hold his breath. This breath-holding leads to some cyanosis which in turn leads to anoxaemic rigidity, which rigidity appears first in the masseter muscles. The ensuing clenching of the teeth interferes in turn with the maintenance of an adequate air-way, particularly when nasal obstruction, a common occurrence, is present. This promotes still further muscular rigidity and a vicious circle becomes established. We are then faced with a patient who is deeply cyanotic, is in a state of extreme muscular rigidity, and who is not breathing. Because of the fixation of the chest, due to intercostal muscle spasm, the attainment of effective artificial respiration may be extremely difficult. Usually, however, relaxation will occur before death ensues and the vital oxygen may be forced into the lungs. It is nevertheless conceivable that in the event of such an occurrence in a patient with some pre-existing cardiovascular damage, death from sudden heart failure might occur. Indeed such accidents have been recorded. Accidents of this character are of an acute asphyxial nature, the presence of the anaesthetic agent being of secondary importance only.

While simple breath-holding may be the factor impairing free pulmonary ventilation, there are other and indeed more common occurrences which may precipitate these crises. Tongue retraction and foreign bodies such as mucus, saliva, vomitus, dislodged teeth or dentures might be mentioned. When an anaesthetic machine is in use too little oxygen in the anaesthetic mixture may eventually set up the same sort of disturbance. When there is pre-existing obstruction of the air-way, due to deep inflammation of the neck, oedema of the glottis or other such causes, the maintenance of an adequate respiration may be impossible. Such cases must be recognized as hazardous for anaesthesia. These are for the experienced anaesthetist.

In the other group the difficulty arises at a later period in the operation but most likely well up in the anaesthetic level rather than at a point close to over-dosage. As examples we may consider those patients who have been under anaesthesia and operation for a considerable period, possibly an hour or more. They will likely have lost considerable quantities of blood and may show the early signs of surgical shock. Blood-pressure readings, which should always be taken in these circumstances, will usually show a progressive fall. The patients will be pale and will present a slight rather than a deep cyanosis. If the operations are continued, signs of respiratory distress become evident. These are irregularity in breathing and very often a "tracheal tug" which the anaesthetist will recognize as a jerk on the hands holding the mask. This respiratory distress may arise even when a light level of anaesthesia has been maintained throughout, but it is much more prone to occur when the operative procedure requires a moderately deep level, with which is associated intercostal muscle paralysis. In these long operations, therefore, the anaesthetist should lighten his anaesthetic whenever possible and deepen it only when imperative. Some of these operations, even in the best-conducted anaesthesia, may terminate fatally. It is in these instances that some differences of opinion between the surgeon and the anaesthetist as to the cause of the fatality may arise. The surgeon may take the stand that he has performed successfully the same operation on numerous other patients, while the anaesthetist maintains that his anaesthesia was conducted without technical error of any kind. Both may be substantially correct, and the only conclusion possible is that the patient has been subjected to conditions, surgical and anaesthetic, under which his vital functions can not be maintained.



*(Photograph courtesy Randolph Macdonald)*

**H. J. SHIELDS, M.B.**

*Lack of Oxygen*

The points commonly overlooked are: that the ability on the part of individuals to withstand these procedures varies tremendously, and that this is a factor not easily recognized prior to the operation. The majority of anaesthetic fatalities which occur in experienced hands will be of this nature. The essential cause of death, like those in the first group, is *lack of oxygen* in the vital centres due to diminution in the amount of haemoglobin circulating in the blood stream and to the gradual decrease in pulmonary efficiency in patients whose ability to utilize oxygen is already impaired by the presence of the anaesthetic agent.

Since many operating-room fatalities are of this nature it behooves the anaesthetist to take the strictest precautions against allowing technical errors of any kind to creep into his management of the entire anaesthetic period. The less experienced anaesthetist too commonly will tolerate a partially-obstructed air-way which the more experienced one will correct automatically as early as possible. As we have seen, a poor air-way, persisting over a period of time, may lead not only to shock in the post-operative period but possibly to a tragedy on the table. *The use of an artificial air-way* might well be made a routine measure. Obstruction due to saliva or vomitus should be aspirated. Mucus in the trachea or larynx necessitates lightening of the anaesthesia to the degree that the offending material will be coughed into the pharynx, from which point aspiration may be accomplished. In short-necked or fat individuals intubation should be practised, either by the nasal or oral route, when the training of the administrator warrants this procedure. Persistent

*(Concluded on page 102)*

# R.C.A.F. Laundry Serves Big Labrador Airport

THE Royal Canadian Air Force, realizing the importance to both health and morale of having clean and sterile linens for barracks and hospitals, and also personal clothes for the airmen, has gone into the laundry and dry cleaning business in a big way. This has been particularly important in overcrowded areas and also in isolated places where no commercial facilities are available. Since the latter condition was most pressing it has been dealt with first, and the R.C.A.F. now has a number of completely modern laundries either operating or in the course of construction.

One of the largest of these plants is at an R.C.A.F. station in Labrador, which handles the laundry and dry cleaning requirements, not only for R.C.A.F. personnel, but for all service and civilian personnel in the area.

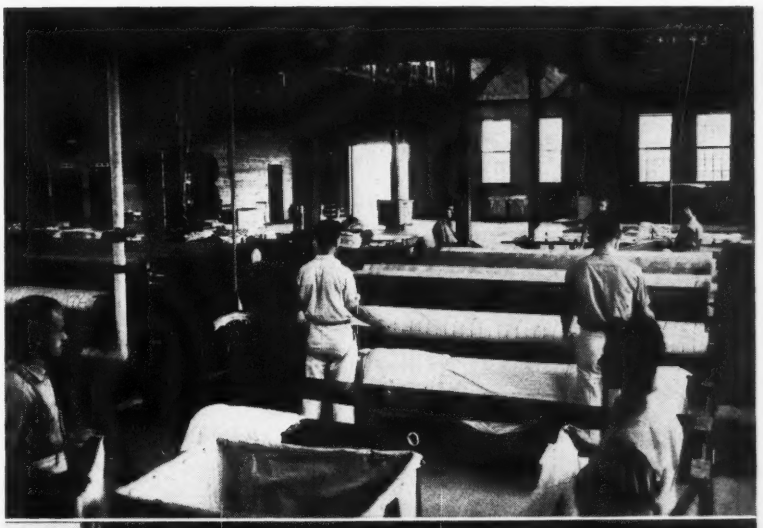
*(Excerpted from an article by F/O J. O. Brown, R.C.A.F., in the "Laundry and Dry Cleaning Journal of Canada", January 1944.)*

Although some of the "headaches" accompanying civilian operations at the present time are not so prevalent in military plants, there are other peculiarities pertaining to service operations which are enough to try the temperaments of those responsible for production. The first and most important of these is the total employment of men for production. In the plant of which we are writing, 95 per cent of the employees had never seen the inside of a laundry before, and the training was a problem for some weeks. However, this was partially compensated for by the uniformity of the work received, the absence of fancy goods and women's clothing, and the ease with which volume coming in could be controlled by the laundry officer, as training of help progressed. Contrary to popular belief, some of the men, particularly the younger ones, showed considerable ability on presses and other types of work. However, production can only be considered satisfactory in a sense of emergency, and it is not felt that male employees throughout a plant will be likely to produce more than 60 to 70 per cent of what female employees would do.

### Well-Equipped Plant

This plant consists of six marking machines complete with booths and conveyor, eight washers, four 48-inch extractors and two smaller ones, seven two-operator shirt units, six wearing apparel units, fourteen tumblers, sock forms, and two six-roll flat work ironers, along with the usual other small pieces of equipment which go to make up a complete plant. Steam is supplied by two 125 h.p. boilers, which are entirely wood-fired. Considering that most of the wood is still growing a few hours or days before it is burned, it is quite remarkable that no difficulty has

*Right: The 6-roll flat work ironers.*
*Below: The battery of shirt units.*



been encountered in maintaining sufficient steam. Practically every last piece of piping in the laundry is well lagged, and the installation of a heat reclaimer has aided considerably in the conservation of steam.

In general, civilian laundry practices are followed as far as production is concerned. No wrapping paper is used except for transient personnel. Each permanent member of the forces is issued two cotton laundry bags, and his work is packed in his own bag for delivery. Hospital and barrack work is picked up and delivered in canvas hampers. Except for a few "Cash-and-Carry" bundles, no cash is handled by the laundry office. The men pay $1.50 per month flat rate for any amount of work they wish to send. Officers and civilians pay piece rates, which are in general about 60 per cent of usual civilian prices.

The question of supplies in a location of this kind is an important one, and since navigation is a governing factor, enough supplies of all kinds must be accumulated to last practically a whole year, making quite a huge stock of stores when it is assembled.

A complete list of spare parts for most machines is kept on hand, and careful maintenance schedules are set up to reduce the chance of shut-downs to a minimum.

To find a laundry of this type in such an out-of-the-way place as Labrador has been rather a surprise to many visitors, and the plant has been a point of interest at the base. In some cases, transients from Canada have brought laundry up with them and returned to Canada with it quicker than they could get it done in their home towns. In other cases, bundles have been left by through transients and delivered by air to overseas points.

As expected, the establishment of this plant has been a decided morale builder, and as time goes on it is felt that it will also have a distinct effect on the health of the personnel.

## REGRETS

**It had been planned that this issue would contain a review of hospital developments in the Canadian Army and of some of the hospital activities of the R.C.A.F. not already covered in a previous article. Unfortunately, owing to pressure of other work, it has not been possible for the officials preparing the data to have this information available to us in time for publication. We hope that it will be possible to publish these articles in a later issue.**

### Why Terry Towels are Called "Turkish"

In 1854 an English millman "discovered" a method of making the so-called terry weave, first known to the Egyptians about 2000 B.C. However, he could not find a market for his cloth in England, so he shipped a boatload of it to Turkey, where it was used for turbans. By 1869 it was back in England by way of English importers, who thought it was a Turkish product and called it "Turkish cloth" or "Turkish towelling".

*—From "Consumer Report" of the Consumers' Union.*

### Athletic Programme Planned for Men in Army

The Canadian Army is preparing a series of sport tests and activities, somewhat comparable to that which has been popularized in Russia. It is understood that a special committee under the chairmanship of Captain D. H. Thomas has been set up to establish the tests and get the scheme into operation.

# Obiter Dicta

## *Soldiers' Dependents*

IT will be a matter of satisfaction to the hospital field that an agreement has been reached between the Dependents' Board of Trustees and the Canadian Hospital Council respecting the financial aspects of the hospital care of soldiers' families. The D.B.T. was set up by the Federal Government to provide financial assistance to soldiers' families, not in every case of illness as some have presumed, but in those instances where the usual assigned pay and allowances do not suffice to meet the costs of prolonged sickness or other emergency. Since its inauguration this Board has been of inestimable assistance to soldiers' families and has paid our hospitals and our doctors a considerable sum of money for services rendered. Naturally the regulations under which this newly-created wartime Board has operated have had some rough corners which have needed adjustment. Interpretations by regional officers have varied. The hospitals have been somewhat "on the spot", for it was realized that some of the restrictions were not fair to them, yet they have hesitated to be too insistent in demanding certain charges lest their actions be construed as lack of sympathy for the dependents of those who are doing so much for us now.

The agreement now effected, and published elsewhere in this issue, is a fair one and should appeal to our hospital administrators. There are other details which some of our administrators might like to have included, but it will be realized that Mr. Pembroke and his Board are endeavouring to make the funds available to them go as far as possible. For many of the cases handled by this Board, the hospitals would receive very little return, if any, were it not for the assistance of the D.B.T. Negotiations are now under way for some such sort of agreement between the D.B.T. and the members of the medical profession.

A considerable responsibility rests on the hospitals to play fair with the Board. Ward charges must not be higher than would be charged to any other paying public ward patient and it is presumed that extras will not be incurred nor charged for to a greater degree than would have been the case had the patient had no connection with the D.B.T. The basis on which charges may be made is clearly stated in the agreement. It will be important, too, that the placing of blank application forms in hospitals does not lead to their almost indiscriminate use by dependents. The sending in of applications should be suggested only when it is obvious to the officials of the hospital that the soldiers' dependents would find it exceedingly difficult, if not impossible, to meet the expenses incurred by illness. The Canadian Hospital Council has assured the Board that the hospitals may be depended upon to give their fullest co-operation to the carrying out of this Agreement.

## *Health Insurance.... and the Hospital Creed*

THE Canadian Hospital Council has laid down as a continuing policy that it desires and is willing to be of any service possible in the working out of any plan of health care which will be of lasting benefit to the sick and will promote better national health.

The hospital supplies the machinery for co-ordinating the knowledge and the thinking of the various groups that contribute to the care of the patient in hospital. It does not give professional service itself, but supplies the means whereby service may be given.

Every proposal must be measured in terms of *securing lasting benefit to the sick* and *better national health.*

This is why the Canadian Hospital Council is interested in maintaining:

1. The voluntary hospital as a continuing service in the community.

2. A high quality of medical care. It co-ordinates the distribution of the professional services of not only the clinician, but the pathologist, the bacteriologist, the serologist, the biochemist, the radiologist, the anaesthetist.

3. High standards in medical education, taking the

long view that if there is lowering we will soon revert to a poor grade of Medicine.

4. An adequate supply of well-trained nurses. This means that nursing service must be made attractive, in order to secure recruits. Adequate salaries and proper living conditions must be provided. There must be sufficient competent instructors to ensure a continuous supply of well-trained nurses.

5. The work of the public health field, which impinges closely on that of the hospital. The Council is interested in *health* insurance as well as *sickness* insurance.

6. Competent pharmacists, and recognizes their important position in the hospital.

7. Laboratories with technologists whose standards of education and efficiency have advanced, and who form a most important link in the service chain.

8. Medical social workers.

Through its co-ordinating function the hospital steers these many skills to the benefits of the patient . . . .

TRUE GROUP PRACTICE.

G.F.S.

## *1,500,000 Postwar Positions*

IT is obvious from the report of the Commons Reconstruction Committee that much progress has been made in focussing the attention of our people on the necessity of creating or re-establishing postwar positions for the many men and women now in the armed forces or engaged on temporary wartime work. This report, really an assembly of opinions expressed by key people in various activities from coast to coast, has been prepared by Dr. G. M. Weir, Acting Director of Training in D.P. & N.H., well known to the hospital and professional groups through his comprehensive report of some years ago on nursing conditions in Canada. In these estimates there may be considerable duplication, and the estimate of 1,000,000 to 1,500,000 jobs may not be confirmed. Nevertheless this report does hold out considerable promise for the more than three-quarters of a million men and women now in uniform and the tens of thousands now engaged in war industries.

The hospital field is deeply interested in this situation and the estimates of likely hospital positions are included in this total. We are quite certain that hospitals will play a major role in the transition of the nation from a wartime to a peacetime footing. Many classes of personnel will find extensive employment in hospitals. Former employees will be re-engaged and many of those taking postwar vocational training in office work, technical work, dietetics, etc., will be taken on. A tremendous building programme is about to break in the hospital field. More inquiries concerning construction are being received at our office now in a month than were received in a year earlier in the war. If but half of the building projects under consideration are undertaken, the stimulus to the building trades will be tremendous. If health insurance is adopted on a broad scale, the need for new buildings will be still further increased. All of this, moreover, means further additions to the permanent staffs of hospitals.

The hospitals, too, will be required to make extensive contributions to the training of various groups. The training of pupil nurses and refresher courses for returning nurses will fall heavily upon the schools for nurses, of course. Approved schools for laboratory technicians are now being set up and, in all probability, many more will be required. More openings for dietitian interns will be needed. In the medical field post-graduate facilities for the giving of refresher and of longer courses to returning doctors will be necessary. The problem of providing adequate training in specialties is now giving much concern to medical organizations. If health insurance follows shortly, not only may more medical schools be required, with the resultant creation of more teaching hospitals, but the need of more qualified specialists will require both universities and the larger hospitals to revamp or establish graduate instruction to meet these certification requirements.

Hospitals might well plan now many of the ways in which they might participate in the postwar transition period, both by providing work on long-deferred developments and by taking part in a programme of vocational training.

## *Our Help Needed*

OUR readers are reminded of the importance of getting behind the new Victory Loan being raised in a few weeks. The staggering amounts that are necessary to carry this war to a decisive conclusion can only be raised if each and every one of us supports this loan to the fullest possible extent. Investment in war bonds provides a three-fold benefit:

(a) Available funds for war purposes;

(b) A backlog of personal assets for the unpredictable postwar period;

(c) Disastrous inflation brought about by unnecessary buying is checked. This last feature should appeal strongly to hospital personnel on stabilized incomes.

In this connection the recent statement by the Governor of the Bank of Canada relative to the federal debt is reassuring. The interest charges on the federal debt have only increased by $135,000,000, namely from $169,000,000 to $304,000,000, from August 31st, 1939 to December 31st, 1943. Moreover through better returns from various sources, the net increase in public debt carrying charges as at December 31st, 1943, only amounted to $75,000,000. The 1943 budget was $5,500,000,000. Total interest charges represent only 5.5 per cent of this amount and 11 per cent of the $2,752,000,000 levied in federal taxes last year. This indicates a much healthier state of national finances than some pessimists would have us believe.

Let every hospital worker—personnel, trustees, visiting staffs, volunteers—do his or her part at this time.

# THE INTERN
## *in the Non-Teaching Hospital*

THE difficulties encountered in providing good internships in a non-teaching hospital were reviewed in a frank and forthright report presented to the College of Physcians and Surgeons of Saskatchewan in December by a Special Committee zoned in Saskatoon and instructed to report on this subject.

This analysis of internships in non-teaching hospitals indicates a practical knowledge of the difficulties encountered. The Committee places its finger fairly on many of the major weaknesses noted in more than one hospital. It is unique in that it tends to favour the internship in a teaching hospital, even though the Committee members represent non-teaching hospitals. (The medical school at the University of Saskatchewan does not extend over the clinical years.) Many of our readers may feel that the report does not lay sufficient emphasis upon certain advantages more apt to be found in non-teaching hospitals.

In justice to the internship services in non-teaching hospitals it might have been stated that for the intern taking one year of internship only, he is more apt to gain experience more in keeping with his own future activities; many of his seniors will be general practitioners and not almost all specialists; and he usually has more opportunity to see and do things than does the junior in a teaching hospital (we include this advantage with some reservations). Actually we know of many highly desirable internships in non-teaching hospitals. It is quite possible that the Committee was somewhat critical of some members of the staffs of non-teaching hospitals with the intent to be provocative and thus stimulate them to greater effort on behalf of their interns.

We are indebted to Dr. J. F. Argue, Registrar of the College and to Dr. W. S. Lindsay, Chairman of the Committee, for permission to publish this Report:

The members of the Committee feel that an intern staff, adequate in number and quality, is invaluable to any hospital and that, even in a non-teaching hospital, there should be sufficient opportunities for clinical experience to make the appointments attractive. Such appointments, however, can never compare with similar appointments in teaching hospitals. The non-teaching hospital operates under very great handicaps. Not the least of them is the fact that the best students are picked up by the teaching hospitals and with few exceptions the non-teaching hospitals get the poorer students.

### Difficulties Encountered

On the other hand the majority of the men on the medical staff of the non-teaching hospitals are unaccustomed to teaching and cannot give the intern the instruction he needs. In many cases they are uncertain of themselves, fear criticism and questions from their interns and rebuff any suggestions they may make.

The net result is a strained relationship and many of the visiting staff fail to make use of the interns and give them no assistance or guidance. This condition is intensified by the increasing shortage of interns which makes it impossible to be sure of a regular supply. The staff members are forced to get along without them with the result that when interns are available they are little used and are apt to feel that they have no place in the working of the hospital.

In Saskatchewan hospitals, all patients are essentially private patients. These patients do not provide good clinical material for training interns who heretofore have had to deal only with public ward patients. Doctors often resent the intrusion of interns in these cases and it is very easy for an inexperienced or tactless intern to create a difficult situation. The main difficulty, however, is that the general organization of the non-teaching hospital is poorly adapted for the training of interns. Saskatchewan hospitals have open staffs, which means that the intern has no one chief to whom he is responsible. "No man can serve two masters". How then can an intern be expected to serve adequately the thirty or forty staff members for whom he is supposed to be working?

In a teaching hospital with a closed staff, each intern is attached to a staff member and between intern and chief there develops a feeling of responsibility and trust. This relationship has perpetuated the best features of the old system of medical apprenticeship and to most of us it remains the most cherished memory of our medical training. Yet in our non-teaching hospitals it does not exist. The intern has no one to whom he can turn for assistance or advice and in like manner he has no one to whom he feels any sense of responsibility.

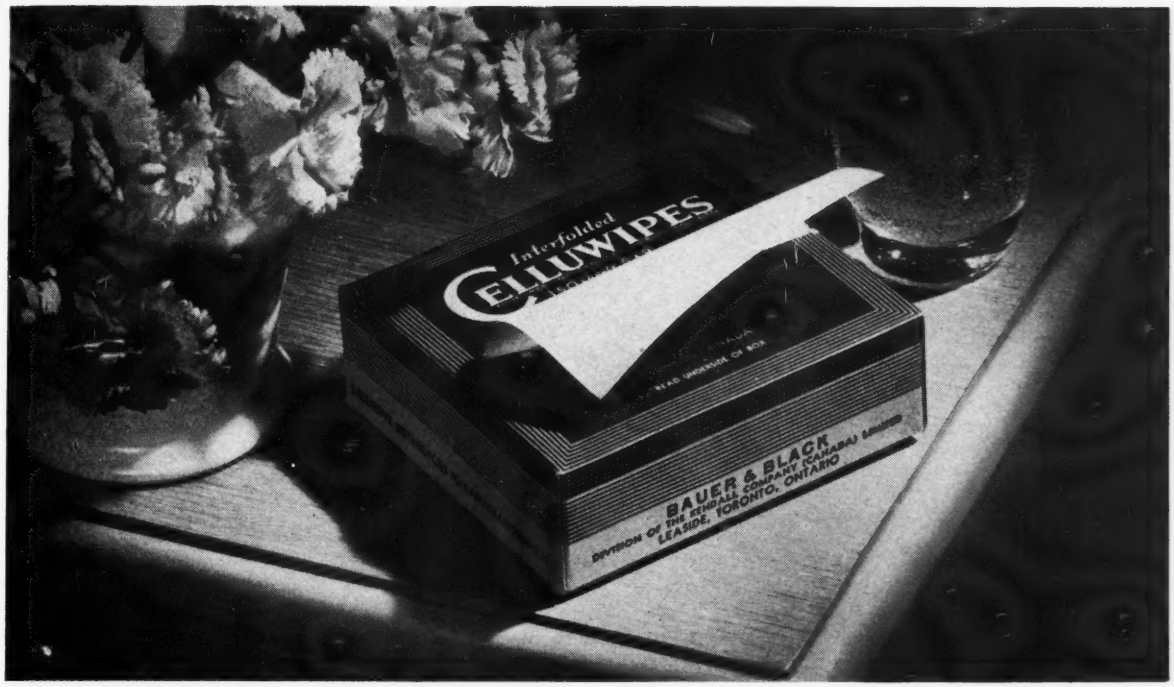
The result is a complete lack of discipline. A medical superintendent might exercise some authority but cannot possibly take the place of the individual chief. History taking becomes little more than drudgery unless it is done to assist a chief who relies on its accuracy for his conduct of the case and can be depended upon to comment favourably or unfavourably on its excellence. Under the present system it is a justifiable grievance that many histories, labouriously written up, are never even glanced at by the visiting doctor.

In teaching hospitals interns not only have the opportunity of sitting in at the regular clinics and conferences but they play an active and essential part in their preparation. Here their work is valuable and constructive and is subjected to open discussion and criticism which forms the greatest possible incentive to accuracy and care. In the non-teaching hospital this stimulating atmosphere is completely lacking.

### Internship in Non-teaching Hospital Offers Useful Exerience

Despite these serious handicaps we feel that the non-teaching hospital can offer useful experience to the young graduate. Although we question if it is the best place for the undergraduate or junior intern who still needs the discipline of organized teaching, it can do much for those who have had some previous hospital experience. But if we are to justify the acceptance for a nominal salary of a year's service from a young man anxious to learn from the experience of his older colleagues, we must make a real effort to provide the supervision and instruction that he needs. No member of the medical staff should expect help from interns unless he is prepared to devote time and

*(Concluded on page 52)*

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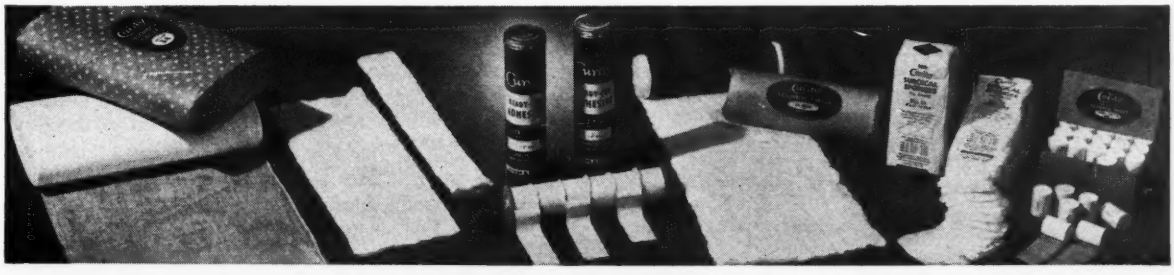

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## Intern Report

*(Concluded from page 50)*

thought to their training. The development of an efficient intern service is a matter of give and take. The intern must be willing to give freely of his time and interest and to spend hours on tedious routine, but he has a right to expect much from the medical staff; failure on either side ruins the service.

At the beginning of the intern year, the Chairman of the Intern Committee, the Medical Superintendent, or some other competent member of the Medical Staff, might well spend some time with the new intern explaining the differences between teaching and non-teaching hospitals and making clear what they may expect from their internship. Also, he might point out with advantage the peculiarities of the private patient and the way in which he should be handled.

It might be a help to have an outline giving routine procedures as used in the hospital, indicating what is required of the intern in the different services, the number of histories he must complete, the anaesthetics he must give, the deliveries and post mortems he must attend and conduct, and all the other duties which make up his year's work. Care must be taken to see that all the facilities of the hospital are made use of. Too frequently the operating room takes the main share of the intern's time and attention. He must be assigned definitely and in rotation to the special services such as Anaesthetics, Obstetrics, Radiology, Physiotherapy, Clinical Pathology and any special clinics available in the hospital.

The simplest, the poorest, method of instruction is the didactic clinic or lecture. The intern is surfeited with lectures and wants most of all to play a practical part in good medical and surgical practice. He is enquiring and critical and wants to know the reason for doing things. Staff men must be prepared to discuss their cases, to explain their diagnoses and methods, and above all to encourage questions and suggestions. Histories must be studied and criticized and the progress notes read. All this will demand a great deal from the staff but will be just as valuable to the staff as to the interns.

### Staff Co-operation Essential

Not all the staff will be capable of doing this, but those who do will reap the benefit in the service they receive. It will not be necessary to withhold intern service from members of the staff who fail in their part of the contract. It will occur automatically and the complaints of such staff members that they are being neglected should not be taken too seriously by the Intern Committee, who would be better employed in helping the more co-operative members.

The needs of the interns should be kept in mind by the Programme Committee in arranging the staff meetings and clinical conferences. Cases prepared and presented by interns, or symposia conducted by interns, followed by staff comment and criticism, would enliven the meetings and maintain interest.

Finally interns might take part in the instruction of groups of nurses in many practical procedures; such as the setting out of instruments for various operations, intravenous methods, transfusions, intubations, aspirations and the like. Here the intern would probably benefit more than the nurses he is instructing.

### Possible Solution

All these comments and suggestions pre-suppose an ample supply of interns. For the non-teaching hospital this appears unlikely. Irregularity in supply is disastrous. It is difficult, after being without interns for a year, to provide adequately for six or seven the following year. Also, one or two interns in a hospital requiring six or more means sloppy work and poor training. If, as appears probable, this is to be the situation in the years to come it would be better for the non-teaching hospital to do without interns altogether and to organize the work accordingly.

We would suggest as a possible alternative to a full intern staff the appointment of a resident physician and a resident surgeon with a staff of nurses trained in the taking of histories and in certain clinical procedures usually carried out by interns. These residents should be relatively senior and should be responsible to the medical staff for the clinical work of the hospital. We do not feel that this plan is an improvement on an intern staff. It would probably be better than the present intermittent supply. Unfortunately, until the war is over there is little chance of there being sufficient medical graduates or nurses available.

As instructed by the Council of the College, the Saskatoon Committee on Interns in Non-teaching Hospitals met on Friday evening, December 10th, 1943. Those present were:

Chairman—Dr. W. S. Lindsay.

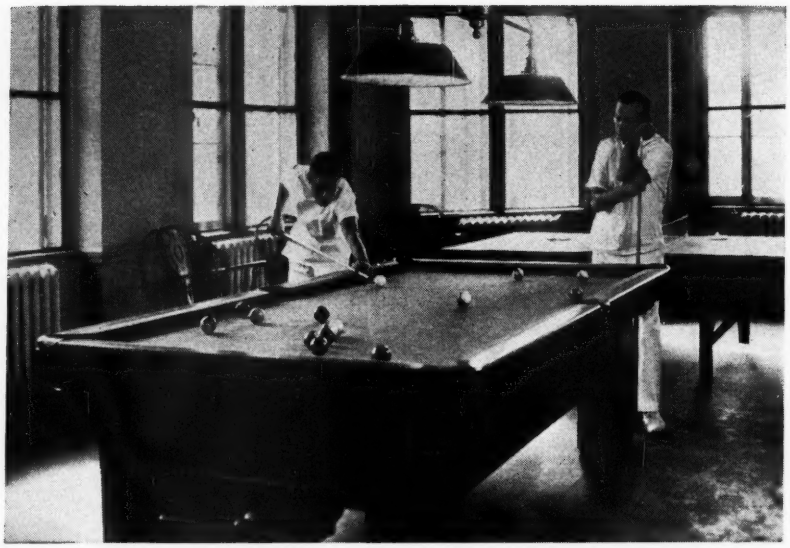
Representing St. Paul's Hospital, Saskatoon:

Dr. R. H. Macdonald, Chief of Staff; Dr. F. E. Wait, Chief of Surgery; Dr. D. M. Baltzan, Chief of Medicine.

Representing the City Hospital, Saskatoon:

Dr. R. H. Macdonald, Chief of gery; Dr. J. F. C. Anderson, Chief of Medicine.

*See "The Canadian Hospital", February 1942.

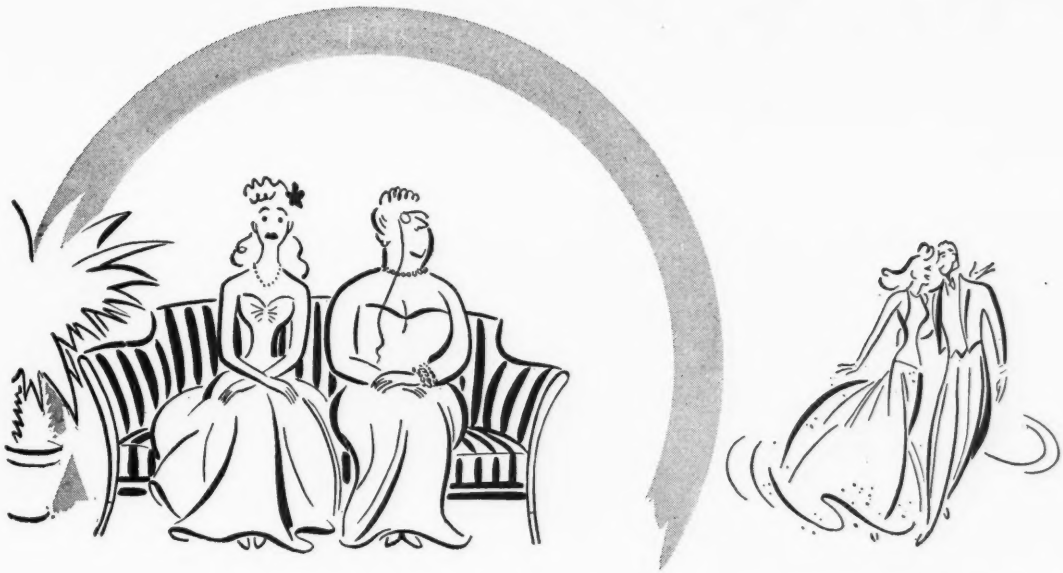


*Interns relax when off duty.*

### Major Eisenhardt Heads Physical Fitness Council

It has been announced by the Minister of Pensions and National Health that Major Ian Eisenhardt, formerly of Vancouver and now of Ottawa, has been appointed Chairman of the new National Council of Physical Fitness to administer the National Physical Fitness Act passed last year. Eight members to the Council have also been appointed by the Minister.

So far five provinces—Prince Edward Island, Nova Scotia, Saskatchewan, Alberta and New Brunswick—have entered into agreement with the Dominion to participate in the national fitness programme.



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# Here and There

**By the Editor**

**"Pride Goeth Before a Fall"**

*(Excerpted, with some condensation, from "A Surgeon's World" by Dr. Max. Thorek.)*

OSCAR, whose full name was Oscar Lincoln Whitesides—although his sides, as well as the rest of him, were actually black as the ace of spades—was suffering from an umbilical hernia. I told him that he must have an operation. I was sorry, but not surprised, to see a look of sheer terror cross his face:

"Doctah! You isn't goin' to take off mah belly button, is you?"

That, of course, had been just what I had intended as an incidental result of the operation. I had been removing belly buttons on occasions with utter *sang froid* for years.

"Yes, Oscar", I said, "the belly button will have to come off".

I was not prepared for the explosion which followed.

"Doctah", he moaned, "there ain't going to be no operation! I aims to keep mah belly button!"

His eyes roved wildly from door to window. Suddenly there was a flash of black and white and one of the interns grabbed a flying figure by the short tail of his hospital gown just as he was disappearing down the corridor. Not for nothing was this man named "Oscar"—the dictionary will give you the meaning—"leaping warrior".

Obviously we were going to have to use persuasion and plenty of it if we ever got Oscar to the operating table. I assigned the job to the Resident and when, two days later, he reported to me that we had the green light, I was pleased with his work.

I congratulated him and I detected some embarrassment in his response.

"How did you get Oscar to sign the permit for the operation?" I queried.

"Well, er . . . you see, Doctor", he stammered. "I just had to tell him you would try to save the belly button!"

I groaned. But I had been thinking about Oscar, wondering whether he didn't have something on his side of the argument. After all, a man's belly button is pretty personal. And if a man values it . . .? He wasn't asking anything beyond the realm of possibility. Hadn't I successfully transplanted many nipples on female breasts? Anyway, I said to myself, a promise is a promise. This one I didn't make myself, but it was made for me. . . .

And so, when Oscar was rolled into the operating room and I went quickly to work to excise the tegumentary structures, I saved the umbilicus and reimplanted it in its normal habitat at the end of the operation. "Nothing ventured, nothing gained", I thought.

I was glad that I had at least tried to keep my promise. For, when I left the operating room, I was waited upon by a veritable army of Oscar's relatives, in-laws, out-laws, neighbours and friends, who lined up in a doleful semi-circle, their big eyes solemnly searching my face. The ponderous dark lady nearest to me was their spokesman.

"I am Mrs. Whitesides", she announced ominously. "We understands you had to tampah wif de belly button of my husban', Oscar Lincoln Whitesides. Is you done it or isn't you?"

I shall never know what dark tribal taboo I might have violated had I been forced to plead guilty at that moment. But my conscience was clear. I adopted the tone of solemnity which the occasion clearly demanded.

"Madam", I said, "in order to reduce the hernia from which your husband suffered, I was forced to excise the button. . . ."

There was a subdued but disquieting murmur from my auditors and I hurried on,

"But I have made a satisfactory graft! I have never, in all my experience as a surgeon, seen a handsomer or neater navel. It is my belief that nothing but death itself can separate your husband from his abdominal adornment!"

Light flooded every face as I spoke. There was a flash of white teeth in now smiling countenances. There were softly spoken words of gratitude.

I hoped when I spoke that I was telling the truth. The days passed and I was sure of it. As the whole hospital staff—suddenly and, I fear, hilariously, became belly-button conscious—watched and waited, Oscar's navel seemed to be healing by "primary intention", smoothly and perfectly. I was proud of it. Dr. Karl Meyer, head of the hospital in which the work had been done, was so impressed that he persuaded me to show off Oscar and his belly button at a meeting of the Cook County Medical Society.

The exhibition was conducted with all the pomp it deserved. Into the amphitheatre rode Oscar in a wheel chair pushed by an orderly. I followed with assistants and interns at my elbow.

"Gentlemen", I said, "I have the pleasure of presenting to you the first successful transplantation of the umbilicus. Henceforth no one need worry about smooth abdomens! You may restore them to their pristine state, thereby satisfying aesthetic tastes. . . ."

With a quick and confident sweep of my hand, I removed the adhesive tape, and stepped back to receive the applause.

It did not come. There was dead silence for an instant and then a gathering roar of laughter. I looked down. The "belly button" of Oscar hung there attached, not to Oscar, but to the adhesive tape!

So Oscar lost his belly button after all. I wish that Oscar, wherever he is, could know that, because of him, many men have been spared the embarrassment of facing the Judgement Day with the smooth

*(Concluded on page 100)*

# With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

*Dear Mr. Editor:*

Recent numbers of *The Canadian Hospital* have contained several important items on the subject of finance which seem to deserve some comment, although I cannot pretend to be an expert on the subject. The first, of course, was in the statement of policy by the Ontario Minister of Health that his Government intends to underwrite general ward care throughout the Province. The item which attracted most attention from the English point of view was his criticism of "the obviously unfair practice" as he described it "of using revenue obtained from the private and semi-private patients to aid in the payment of general ward care". This is not a point which I have ever heard from the patients themselves. On the contrary it is not an uncommon experience to find that the patients in the private accommodation provide quite an appreciable proportion of those who become subscribers to the charitable work of the hospital. Not only that, but in fixing the charges made to the private patients care is always taken so that there is a margin, in order to avoid any possibility of a call upon the charitable funds. Although that can hardly be described as a profit, it is a balance which, in the aggregate, may provide a useful sum towards the running of the hospital.

## Some Financial Problems Reviewed

### "Units of Credit" System

Upon the ingenious system for payment of hospitals, permit me to offer my congratulations to you, Sir. The underlying principle was accepted here to a small extent in the war of 1914-1918. The Ministry of Pensions made two scales of payments, according to whether the hospital was a teaching hospital or not. So far there has not been any arrangement of that kind, though proposals on the same lines have been under consideration.

But at ordinary times the basis of negotiation is often not the services which are being rendered to the patients in the hospital as a whole, but what the services are worth to the negotiating authority for the particular patients for whom they are making payment.

The proposed system, if I may say so, does seem to be trying to kill two birds with one stone, namely to fix a basis of payment and to stimulate improvement.

### Teaching Hospitals

Under war conditions we have all been generally agreed that it is impossible to have working departmental costing schemes, so that I am not in a position to offer any figures bearing upon the details. There does not seem to be any necessity, as they have already been examined by experts and no doubt further light will be thrown upon them by experience. But the figures which are given of the respective costs of teaching and non-teaching hospitals are particularly interesting, as they correspond very closely with those which have been ascertained in this country. It has been calculated that the teaching hospital ranges somewhere between twenty and twenty-five per cent more than the non-teaching hospital.

The subject was examined in some detail for the information of a Ministry of Health Committee which is considering the future of hospitals with medical schools. It was submitted that the fact of teaching being conducted in a hospital leads to additional expenditure in every department. For example, the greater variety of cases collected in a teaching hospital because of their value for clinical instruction means the preparation of a much higher proportion of special diets and the use of expensive patent and special foods. Drugs, dressings and instruments are obviously all affected in a similar way. The whole organization of the hospital, it was pointed out, is on a more elaborate scale, which has an indirect as well as a direct effect upon expenditure. The larger staff requires more accommodation, and that in its turn needs more cleaning. There is greater movement of patients between departments and that also demands more manpower. The senior staff, who are more often in attendance, have others attached to them on a larger scale than in the non-teaching hospital, and that has an effect through all grades. Then, of course, there is a higher average number of nurses available per bed. Surveying the whole position it was found that there were standard services to be provided by all teaching hospitals, and the average cost for them could be determined from the figures collected by King Edward's Hospital Fund.

In order to estimate the teaching facilities provided it would be necessary to take into account the ratio of students to the number of beds. It is necessary for obvious reasons to watch and maintain this balance. It was thought that an average of thirty students per hundred beds would seem to be about right. Following this line of thought, it is envisaged that a state grant might be made on the basis of the number of students as related to the cost of the beds which, on a pre-war figure, was put at £220 a year. The state grant, of course, would only be a percentage of the total figure. Some hos-

*(Concluded on page 94)*

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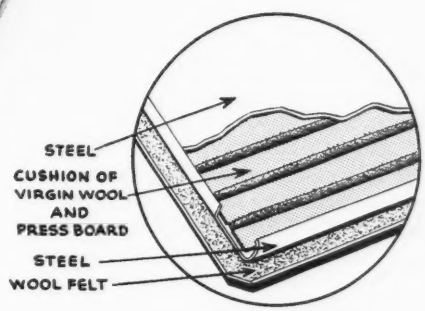


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# *Better* INTERNATIONAL RELATIONS *Can be Fostered Through our Hospitals*

By G. H. A.

THE holding last month in Mexico City of the Second Inter-American Institute for Hospital Administrators, focuses attention upon what has already been done towards the establishment of better and closer international relations in the hospital field, and the desirability of further activity in the immediate post-war period.

Since the collapse of the International Hospital Association at the outbreak of war and immediately prior to its scheduled meeting in Toronto, a number of steps have been taken to maintain international relations in the hospital field and to pave the way for the setting up of a new organization in the postwar period which will be free of the Nazi domination which made it so difficult to obtain the necessary co-operation in the old organization.

At the Toronto A.H.A. convention in 1939 a Latin-American Committee in the American Hospital Association was set up to bring about a closer relationship between the countries in the three Americas. Two years later, at the Atlantic City meeting, the Inter-American Hospital Association was formally organized. Dr. Jose Jacome of Columbia was named president, Mr. Felix Lamela of Puerto Rico was selected as secretary-treasurer and Dr. M. T. MacEachern, whose energy and enthusiasm had paved the way for this memorable meeting, was named honorary president.

Realizing that for a few years to come the Inter-American Hospital Association would experience some difficulty in standing on its own feet and working out a programme of activities, it was agreed at the 1943 meeting of the American Hospital Association in Buffalo to set up a Council on International Relations, as one of the permanent councils of the Association. Dr. MacEachern was named chairman and a strong Committee, with various international affiliations, was selected. It is hoped that this Council on International Relations can be of considerable assistance to the Inter-American Hospital Association during these early years.

The Inter-American Hospital Association has been given substantial assistance by the office of the Co-ordinator of Inter-American Affairs at Washington, which has made these funds available through the Pan-American Sanitary Bureau, which is the public health centre of the twenty-one American republics. The Pan-American Sanitary Bureau is a very essential link in the relationship of the A.H.A. Council on International Relations and the Inter-American Hospital Association to activities in Central and South America. Originally concerned with public health measures for the control of epidemics and a programme of preventive medicine, the activities of the Pan-American Sanitary Bureau have been enlarged to include all hospital problems. It is essential, therefore, that the Pan-American Sanitary Bureau approve policies and programmes which would affect hospitals in these other countries. This relationship has been facilitated by the inclusion in the Council of Dr. Edward C. Ernst of the Pan-American Sanitary Bureau.

To enable him to act as secretary of the new Inter-American Hospital Association, Mr. Lamela was given leave of absence from the School of Tropical Medicine at Puerto Rico by its Board and that of Columbia University with which the School is affiliated. At the expiration of this leave of absence the position of hospital consultant to the Pan-American Sanitary Bureau was created, thus affording Mr. Lamela the opportunity to continue on as secretary of the new Association.

In co-operation with the American College of Hospital Administrators, a definite programme, or what is known as a "Five Year Plan", has been set up. The A.C.H.A. took a very active part in the Puerto Rican institute two years ago and, it is anticipated, will continue to do so during the next five-year period. Following the institute in Mexico it is anticipated that another will be held in Lima, either later this year or early the following year. Other institutes now being projected are for Rio de Janeiro, Havana, Santiago de Chile, New Orleans, Sao Paulo, Puerto Rico, Panama and Buenos Aires. At the rate of two institutes a year, this would carry through to 1948. It is hoped also to provide university courses and travel fellowships, to set up an official journal in Spanish and Portugese and to arrange for translations of approved manuals into Spanish and Portugese and of approved Spanish and Portugese articles into English.

#### Europe and Asia

Because of the chaotic condition of both travel and postal communication to Europe and Asia, it has been necessary during these war years to direct attention to the possibility of developing closer inter-American relationships. It is hoped to establish very close relationships with the various countries in the British Empire and with the various United Nations of Europe and Asia as soon as war conditions will permit. With this in view the activities of the Council on International Relations have been divided into two broad divisions—that of inter-American affairs being under the direction of Reverend Father Bingham of New York and that of Europe and the Orient to be directed by Dr. Agnew.

The Council is fortunate in having as one of its members Dr. James

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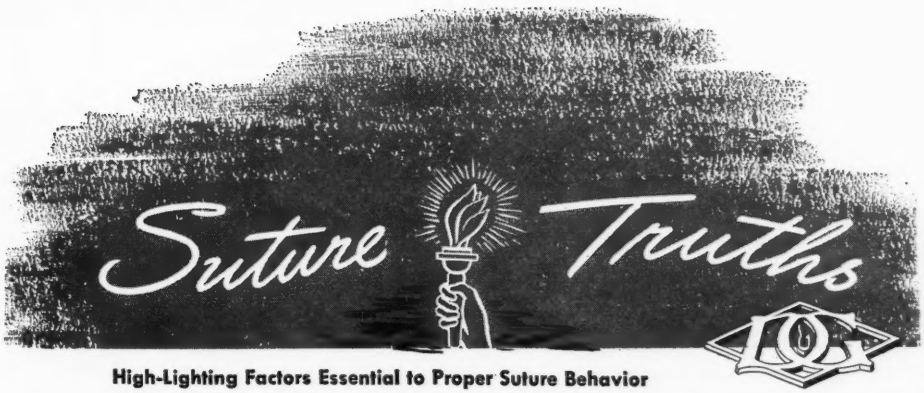


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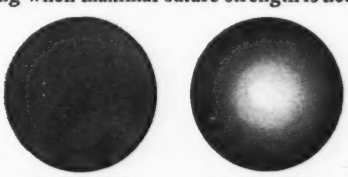
The D & G post-tanning process perfected through more than a third of a century of research and extensive clinical evidence, eliminates this defect in behavior by providing individual treatment of each size. Under this method the finest size is the most thoroughly tanned, the next larger slightly less, and so on—each to the exact degree required to insure proper absorption. Since the process is applied to completed strands of known diameter, it can be controlled with great accuracy to produce sutures of predictable behavior regardless of size.

Another shortcoming of sutures produced from pre-tanned gut derives from the fact that the outer surface is no more thoroughly tanned than the center. Since absorption takes place in proportion to the area exposed to tissue fluids, this means that such sutures lose strength most rapidly in the early stages of healing when the wound is weakest.

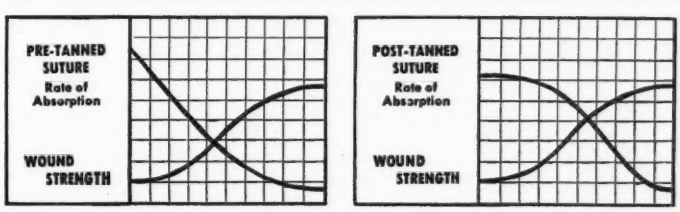
This is exactly opposite to the proper function of a suture which is to RETAIN its maximal strength during the early stages of healing, and then to disappear rapidly as the wound gains strength.

Under the D & G post-tanning method, the outer surface of the strand is tanned to a greater degree than the center. This protects the outer surface from absorption and preserves the original size and strength of the suture during early healing when maximal suture strength is needed.



PRE-TANNED POST-TANNED

By the time the outside of the post-tanned suture is absorbed, healing will be well under way and prompt absorption of the suture desirable.



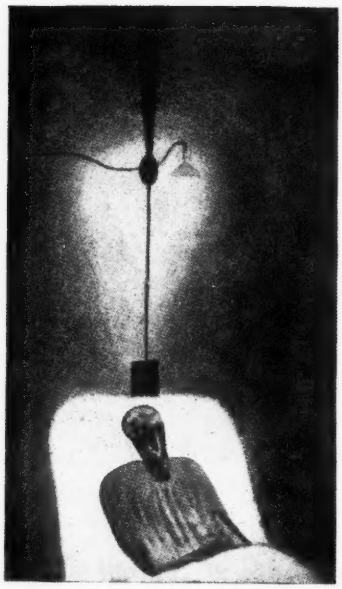

The curves demonstrate how the pre-tanned suture loses strength rapidly in early stages of wound-healing, whereas the post-tanned suture retains maximal strength during this period when strength is most needed.

**DAVIS & GECK, INC., BROOKLYN 1, NEW YORK, U. S. A.**

**An Experiment in Occupational Therapy**

# Art as an Aid in Illness

**By ADRIAN HILL, R.B.A.**



*(Mr. Adrian Hill, R.B.A., the well-known British artist, gives an interesting account of the successful experiment he conducted in stimulating an interest in art among the patients of a famous sanitorium in England. The story is excerpted from "The Studio", published in London, with the kind permission of the author and the publishers.)*

A DESIRE for self expression is inherent in us all, and to encourage this urge at a time of physical inaction might very well re-awaken a latent talent for drawing and painting. Having obtained therefore the ready collaboration of the medical superintendent of a famous sanitorium in the south of England, I put my project into operation, first in the ward for service casualties and afterwards in the more permanent departments for civilian patients.

Likely students were sounded, and after one or two preliminary talks on picture making, I found my audience all eager to listen to any scheme whereby the tedium of their illness might be alleviated and their inward vision turned to contemplate a prospect free from association with their disability. At first there was proof of their genuine curiosity to hear more about "this painting business", and this soon developed into a desire to grasp this opportunity of indulging in some form of self expression, perhaps for the first time.

The benefits to be engendered should grow out of their happy occupation in the job, rather than be sought for in the purely aesthetic value of the finished product.

While our leisure periods in normal health are so fleet of foot, those in a sanitorium, however well organized they may be, have a lamentable habit of dragging with laggard step. Hence a picture "on the stocks" is worth many impressions dashed off at top speed, and this policy of going slow will help to explain the detail finish displayed in the accompanying reproductions, a quality which must invite our respect.

One or two alternative subjects are generally suggested, such as "View from my Window", "Windy Day" or merely "Optional", and if one rule is enforced it is that there should be no copying, reminding them of Clive Bell's definition that "Art is the expression of something alive, and not the imitation of something that was alive once". Making "roughs" is also recommended before starting on the final composition, which should always be enclosed in a definite shape and presented as attractively as possible, even to "tipping in" their drawing on a piece of fresh paper.

My class naturally varies in size from week to week according to the state of health of the individual. Half my usual number of patients are "bedders" who are visited in turn and their work and problems discussed, after which a general "show up" and criticism is given to those who are officially "on rest" and are up to all meals.

With regard to the actual method of instruction, I have always to remember that much depends on the asthenic mental condition of the patient. In some cases emasculation prevents them physically from carrying out their ideas, and when this is the case we talk instead about some interesting aspect of picture-making or together look through some reproductions of the Old Masters, so that the cultural interest is retained until such time as they feel strong enough to take up their pencil and brush again.

Occasionally I find it difficult for

*(Concluded on page 98)*

*Some excellent examples of work done by patients in bed.*

*Above: "Barmecide" by Frank Breakwell.*

*Left: 'Nightlights" by Joan Milroy.*

# Taking Employees into Partnership

**Semi-Monthly Letters at R.V.H.**

AT the Royal Victoria Hospital, Montreal, memoranda to the employees are being prepared and distributed every two weeks. These memoranda deal with a variety of general subjects and are designed to keep the personnel well informed on a number of topics of vital concern in the operation of a hospital. At this time when the staff is undergoing so many changes, brief house letters of this type can do a great deal to promote greater co-operation and understanding.

Mr. Arthur W. Smith, assistant to the superintendent, has sent us a number of these memoranda. Two sample copies are here quoted, one on "Accidents" and the other on "Fire Prevention".

* * *

## ACCIDENTS

Can hospital employees prevent accidents? This question can be answered in one word, "Yes!" All too many accidents occur simply because the employee fails to use commonsense.

We realize that with the shortage of employees and the increase of hospital patients speed seems to be more in demand. But do not accidents cause far more delay than the amount of time we gain by hurrying?

Accidents not only cause the loss of lives, but are very costly. In these days when equipment is in some cases beyond replacement and repair, we must be more careful. Please show that you can do your part.

*Let us note some accidents and their remedies.*

### Overloading Elevators

Each elevator has a printed sign which gives the maximum number of persons to be carried. It is up to each of us to respect this and assist the operators.

### Failing to properly sort linen, dressings, etc.

Scalpels, broken glass, cutting needles, etc, *must not* be left with materials going for wash or salvage. This not only causes injury to employees but destroys linens, which under present conditions, are most difficult to replace.

### Damaging Walls, Beds, Doors, etc.

There are far too many accidents of this type happening in the hospital. These necessitate costly repairs as well as giving the hospital a poorly-kept appearance. Beds, glass, wood and paint are difficult to secure and it is up to us to conserve them.

### Is Everything in its Proper Place?

Accidents are caused by leaving equipment around, whether it be a truck or a broom, so that a person will trip and fall, thereby injuring himself or breaking much-needed supplies.

### Reporting of Defects

All defective equipment, no matter what it is or where, should be reported immediately, so that the proper steps may be taken to make repairs. This avoids more costly repairs later and eliminates accidents which could cause injury to patients, staff or visitors.

* * *

## FIRE PREVENTION

What can we do as hospital employees to prevent fires in peace and wartime?

1. All waste must be carefully placed in containers provided.
2. Don't leave gas jets going unnecessarily and be sure they are fully shut off.
3. Smoking in prohibited areas must be stopped.
4. All electrical cords, etc., must be inspected regularly and any defective parts repaired immediately.
5. All inflammable materials must be properly protected.
6. Avoid accidents which may cause fire.
7. Don't use electric fixtures for clothes hangers.
8. Don't overload electric outlets.
9. Don't use extension cords unless specially installed for use by the hospital maintenance staff.
10. Make sure equipment is being used on the proper current—D.C. or A.C.
11. Make sure that matches are safely protected.
12. See to it that all cigarette butts are properly put out.
13. Eliminate any unnecessary drafts which could spread fire.
14. Don't block fire exits.

Should a fire occur, *notify the switchboard immediately* and give its exact location.

Should you use any piece of fire-fighting equipment, don't put it away until properly inspected by the Chief Engineer.

---

## Use of Male-Volunteers Endorsed by Administrator

Miss Irene M. Baird, R.N., '43 graduate of the course in Hospital Administration given by the University of Toronto and now administrator of the North Adams Hospital, North Adams, Mass., has given an interesting account of the hospital's use of male volunteers to aid the harassed nursing staff.

"Various organizations in the city had made financial contributions to the hospital, and it occurred to me that the men's fraternal organizations might be a source of volunteer supply. Accordingly I appealed for male volunteers who could be trained in simple duties for male patients and thus relieve the nurses for more professional work."

The response to this appeal was highly gratifying, and the 16-member class settled down to two instruction periods a week, from 7.30 to 9.30 in the evenings. The periods comprised both theory and practice, and instruction was given in taking of temperature, pulse and respiration, stretcher service, catheterization, baths, care of pre and post-operative patient, value of fluids, etc.

Upon completion of the "course" the volunteers were assigned to the male wards during the busy evening period of 8-10.

Thus the hospital has not only obtained a very valuable source of volunteer effort, but has enlisted the support of an influential and public-spirited group—a step which will be beneficial to both parties, now and in the future.

# Control Board Rulings

**Priorities**

The priorities regulations announced in *The Canadian Hospital*, September, 1943, have been revised, the new regulations going into effect on February 21st, 1944. The former orders PO 5, PO 5A, PO 4 and PO 4A have been revoked and are replaced by PO 5B and PO 4B.

These new orders are revisions of the previous ones only, and do not involve any major changes in procedures. The effect of the new orders will be to further clarify existing procedures and to reduce the number of individual applications for United States priority assistance which are currently required.

PO 5B prescribes the method by which preference ratings assigned by the United States War Production Board may be used by Canadian importers when purchasing maintenance, repair and operating supplies or minor capital expenditures in the United States.

The procedure is outlined under the Order by which Canadian importers (with certain specified exceptions) may automatically extend United States preference ratings to purchase orders placed with United States suppliers calling for delivery of materials *for use as maintenance, repair and operating supplies, and minor capital expenditures.* Section 2 of the Order defines the types of purchase orders to which preference ratings may be applied under the terms of the Order. Persons placing such purchase orders are not required to submit any application to the Priorities Branch for a serial number or other authority, but may automatically apply United States preference ratings to the extent authorized by the Order.

The differences between Order PO 5 and Order PO 5B may be summarized as follows:

1. The distinction between "Class 1 Importer" and "Class 2 Importer" as originally defined in Order PO 5 has been eliminated, and the new Order PO 5B applies to all importers (with few exceptions) regardless of the classification or dollar value of materials imported.

2. The coverage of "maintenance", "repair" and "operating supplies" remains unchanged, but the provisions of the Order have been broadened to include certain materials defined as "minor capital expeditures".

Capital equipment or constructions materials not exceeding $150 in laid down cost for any one complete addition may be purchased by an institution or a Governmental agency which is not engaged in production for military use. The term "one complete addition" includes a group of items customarily purchased together and all items which would normally be purchased as part of a single project or plan; materials for any one complete addition shall not be divided for the purpose of coming within this definition.

3. Revisions have been made in the classification of businesses, services and activities under Schedules 2, 3 and 4 to Order PO 5B. (Hospitals remain in the AA-1 Preference Rating.)

PO 4B applies only to purchase orders for materials placed by any person in Canada with a supplier within Canada, and does not apply in any way to purchase orders placed with United States suppliers.

The chief differences between the original Order PO 4 and the revised Order PO 4B are:

1. The descriptions of the 24 classifications listed in Schedule 1 have been re-worded for greater clarity.

2. In addition to the classification by code number, purchase orders for maintenance, repair and operating supplies or minor capital expenditures must also be identified on the order as "MRO" and purchase orders for capital equipment as "Capital Equipment".

3. The list contained in the original Order of certain items which could not be coded as maintenance, repair or operating supplies has now been eliminated.

4. The descriptions of several PSC's (including PSC 21) have been broadened to include those materials which are defined as "minor capital expenditures".

5. Some revisions have been made in the classifications of businesses; (hospitals remain under PSC 21).

Copies of these Orders may be obtained from your nearest Office of the Priorities Branch, Department of Munitions and Supply.

* * * *

**Effect of Charitable Donations on Income Tax**

The February issue of *The Canadian Hospital* contained a ruling by Mr. C. F. Elliott regarding tax exemptions on charitable donations to hospitals. This ruling has been modified twice since then. As a background we quote a statement by Mr. Ilsley, speaking in the House:

"The present law allows a business concern as a deduction, in computing profits subject to tax, an amount not exceeding 5 per cent of its income which has been paid by way of donation within the tax year to any charitable organization in Canada operated exclusively as such and not for the benefit of private gain or profit of any person. As a result of allowing this deduction in computing profits for tax purposes, the government foregoes collecting tax which would otherwise be due. In effect, then, the government can be said to be subsidizing charitable activities. Before the war, when the corporation income tax rate was 15 per cent, the government relinquished 15 cents of tax revenue on every dollar contributed to charity. . . . Today, when the minimum tax payable by corporations is 40 per cent, the government gives up at least 40 cents in tax for every dollar of charitable contributions made by the corporation. . . . I have just referred to the case where a company is paying a 40 per cent tax rate. . . . In making a contribution towards charity of, say, $100, the company is (only) parting with $60.00 of shareholder money. . . . In the situation where the business concern is paying tax at the rate of 100 per cent on excess profits, a contribution to charity reduces the company's tax bill by exactly the same amount . . . and this donation to charity is entirely at the expense of the treasury."

On January 31st Mr. Ilsley announced that "It is the intention of

*(Concluded on page 96)*

# IN HYPOPROTEINEMIA WITH DEHYDRATION

WHEN PLASMA AND DEXTROSE IN SALINE ARE INDICATED

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# American College of Surgeons Holding Wartime Sessions

THE American College of Surgeons is now holding a series of War Sessions in various areas throughout the United States and Canada. The schedule of the 1944 War Sessions began on February 28th with a meeting in Winnipeg for Manitoba and Saskatchewan doctors and hospital workers.

Between that date and April 27th some 21 regional meetings will have taken place. On March 15th the Ontario meeting will be held in Toronto and on March 17th a meeting will be held in Montreal for Quebec, New Brunswick, Nova Scotia, Prince Edward Island and Newfoundland. At each one-day meeting separate programmes have been prepared for the medical profession and for the hospital conference. Dr. W. E. Gallie of Toronto is president of the College this year.

### Winnipeg Meeting

Among the speakers were Dr. Harry Coppinger of Winnipeg; Mr. Alex. Esson of Saskatoon; Mr. Everett W. Jones, formerly of Washington and now of Chicago; Miss Gertrude Hall, Reg. N., of Winnipeg; Mr. Clarence C. Gibson of Regina; Dr. Neil E. McKinnon of the University of Toronto; Dr. F. W. Routley, National Commissioner, Canadian Red Cross; Dr. Owen C. Trainor of Winnipeg; Miss Margaret Street, Reg. N., of Winnipeg; Dr. Thomas B. McKneely, Chief, Hospital Section, Office of Civilian Defence, Washington; Philip W. Dawson of Winnipeg and Rupert Reece of Winnipeg.

Dr. A. E. Archer of Lamont, Alberta, addressed the joint luncheon of the two sections.

### Toronto Meeting

At the Toronto meeting, to be held on March 15th, following military motion pictures starting at 8.30 in the morning, a programme dealing wtih wartime hospital problems will be presented. Among the subjects considered will be professional services in wartime, nursing services and non-professional personnel under wartime conditions, graduate training for returned medical officers, communicable disease control, interns and residents, recruitment of student nurses, volunteer services, priorities, protective services, hospital service plans and the care of soldiers' dependents.

Speakers will be Mrs. E. Muriel Cariss of Brantford; Mr. R. Fraser Armstrong of Kingston; Dr. Charles B. Parker, Toronto General Hospital; Miss Mary E. MacFarland, Reg. N., Toronto General Hospital; Miss Helen L. Potts, Reg. N., of Woodstock; Dr. Malcolm T. MacEachern of Chicago; Major Carl Aberhart, R.C.A.M.C.; Dr. Harvey Agnew, Toronto; Dr. W. Douglas Piercey of Ottawa; Miss Jane Masten, Reg. N., of the Hospital for Sick Children, Toronto; Miss Edith G. Young, Reg. N., of Peterborough; Wm. S. Brines, Chief, Hospital Section, War Production Board, Washington; Dr. W. P. Dearing, Chief Medical Officer, Office of Civilian Defence, Washington; Mr. N. H. Saunders of Toronto and Mr. Lester Keachie, K.C., of Toronto.

The luncheon address will be given by Major-General Norman T. Kirk, Surgeon-General, U.S. Army, who will speak on war surgery. In the evening, following the dinner to which hospital representatives are invited, Dr. Malcolm T. MacEachern will discuss a programme of graduate training in surgery and the surgical specialties, after which there will be a forum for general discussion, with speakers through the day participating as the panel of experts.

### Montreal Meeting

The Montreal meeting will follow the general outline of programme adopted in Winnipeg, Toronto and other meetings. The discussion will relate to wartime hospital problems in the different services, with special papers on the medical hazards in warfare by Brigadier J. C. Meakins, D.D.G. M.S., Canadian Army and on the venereal diseases problem by Dr. Elphase Lalonde.

Other speakers will be Mr. J. H. Roy of Hopital St-Luc, Montreal; Dr. A. L. C. Gilday of the Montreal General Hospital; Dr. C. J. Tidmarsh of the Royal Victoria Hospital, Montreal; Miss M. Flanders, Reg. N., of the Children's Memorial Hospital, Montreal; Dr. W. H. Delaney, Jeffrey Hale's Hospital at Quebec; Dr. Malcolm T. MacEachern of Chicago; Dr. Adelard Groulx of Montreal; Dr. George F. Stephens, Royal Victoria Hospital, Montreal; Dr. John C. Mackenzie, Montreal General Hospital; Miss Kathleen Ellis, Reg. N.; Mrs. Alton Goldbloom of Montreal; Mr. Wm. S. Brines, Chief, Hospital Section, War Production Board, Washington; Dr. W. P. Dearing, Chief Medical Officer, Office of Civilian Defence, Washington; Mr. E. D. Millican of Montreal; Senator H. A. Hugessen, K.C., of Montreal.

Speaker at the luncheon will be Major-General G. B. Chisholm, D.S.O., M.C., Director General Medical Services, Canadian Army, who will speak on current problems in medical manpower for the armed forces, hospitals and the civilian population. The dinner speaker in the evening will be Vice-Admiral Ross T. McIntire, Surgeon General, U.S. Navy, who will speak on surgical problems in the Pacific areas.

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### No Flowers after 3 p.m.
### Toronto Hospital Council Decides

Arrangements have been made between the Toronto Hospital Council and the Florists' Association whereby it will be understood that hospitals in Toronto will not be expected to receive flowers after 3 p.m. Any flowers sent in after that hour may not be taken to the patient's room until next day. Negotiations are under way to ascertain if it will be possible to have flowers sent to hospitals in standard containers which can be taken directly to the rooms without re-arrangement.

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Always follow your operating directions. Duplicate copies on request. Be sure to give serial number on your equipment.

Old water Sterilizers are still giving reliable service. Be sure that yours is in first class operating condition. Below we list several common troubles together with their simple solution:

**SLOW FILLING?...** Clean or replace the filters. Check filter gaskets.

**SLOW HEATING?...** *Electric*—Check fuses. Clean heater element.
*Gas*—Clean burners. Check pressure.
*Steam*—Check steam pressure. Check trap on return line.

**SLOW DRAW-OFF?...** Free air valve to break vacuum.

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# CASTLE STERILIZERS

**A WRENCH PROPERLY APPLIED WILL WORK WONDERS**

Do not allow minor troubles to go unheeded and multiply to a point where the safety of your technique would be threatened.

**Dr. and Mrs. G. A. MacIntosh Present Library**

*In memory of Captain Ian Harris MacIntosh, killed in action in Sicily some months ago, his parents, Dr. and Mrs. George A. MacIntosh of Halifax, have formally presented the young officer's personal library for use at Queen Elizabeth High School in Halifax. Dr. MacIntosh is superintendent of the Victoria General Hospital in Halifax and Mrs. MacIntosh is a well-known writer and dramatist. Shown in the above picture, taken by the Halifax Herald, are R. E. Marshall, principal of the school, Mrs. MacIntosh, James E. Myrden, chairman of the Halifax School Board, Dr. MacIntosh and Dr. F. G. Moorhouse, supervisor of schools.*

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## International Relations

*(Concluded from page 58)*

Crabtree of the Office of Foreign Relief and Rehabilitation Operations, Department of State at Washington. Dr. Crabtree has made an intensive study of the immediate and postwar needs of the various countries affected by the war, and has been able to focus the attention of the Council upon international problems that must be handled now and are not confined to a more remote postwar period.

The present situation in many of the devastated countries is particularly serious. Many of the hospitals have been stripped by the armies of occupation—stripped of instruments and of supplies. In many cases the metal beds have been taken, and patients are required to sleep on the floor or on makeshift beds. Everywhere there is danger of typhus.

Many of the hospitals in western Europe could get back into operation with little help other than supplies if no further damage were done to them as the Germans retreat. This, however, is problematic. In other countries, however, such as in Poland and Greece, personnel as well as facilities are badly needed. In Poland 50 per cent of the 10,000 doctors at the outbreak of war were Jewish, and of these between 80 and 90 per cent have been liquidated. It is estimated that Poland alone will need at least 2,000 more doctors in the postwar period if the people are to be given proper care and epidemics prevented. Greece has a situation very similar to that of Poland, and in China the situation is much more acute still.

At a recent meeting of the Council in Washington some discussion took place as to the procedure for providing hospital facilities in the liberated countries. Immediately after liberation, A.M.G. (Allied Military Government) will take over. At a time to be determined by the military commander, UNRRA (United Nations Relief and Rehabilitation) will take over until such time as the people themselves can carry on. Not only could the Council be of considerable assistance during this latter period, but also during the time of UNRRA direction, for UNRRA will need small teams of experts to advise with respect to organization, etc., in the various countries. Since varying degrees of chaos are to be expected in the hospital work of various re-occupied zones, there may be need of expert personnel who could be supplied to the governments of occupied countries for the reconstruction and rehabilitation programme. Much technical advice may be needed also with respect to hospital supplies and equipment.

Back in 1939, when the International Hospital Convention Committee in Toronto realized that the International Congress was off (and its members were wondering how they would finance the $8,000 expenses already incurred in anticipation of the meeting), plans were formulated for the new international body which would arise at the conclusion of the war. Although these world plans were somewhat eclipsed by the more immediate programme of establishing closer relationships with Central and South America, plans were laid for the holding, in the postwar period, of meetings alternately in America and in Great Britain, say every two years, at which as large a delegation as possible from across the water would be in attendance and would assist in providing the programme. In other words groups from this side would go to Great Britain every four years. As soon as possible other United Nations would be included, and when the time would seem propitious a new International Hospital Association would be set up. Although the completion of these plans may need to be delayed for some years yet, the preliminary steps necessary to work out a basis of organization are now being taken.

# How to Conserve Supplies

IN the conservation of hospital supplies, the important steps will be those of seemingly minor nature. Matters of routine caution in the past now call for special concern and constant vigilance.

Although it is advisable at all times to have a thorough and periodic review of technique, this is doubly important now. In these days of high pressure and high personnel turnover, the damaging of goods and property through bad technique is not only more accentuated, but also more likely to escape immediate notice.

The Committee on Conservation of the Council on Administrative Practice (A.H.A.) presents here the results of a study on the means of conserving hospital supplies.

*Nickel-bearing Materials*

Hypodermic needles may be sharpened from six to fifteen times before they become unduly short if proper sharpening technique is used. The procedure is simple when done by an intelligently trained person with good vision, working in an environment of good light. This applies not only to those of stainless steel, but also to the larger carbon steel needles and platinum needles. Especially valuable: trocar, tonsil, spinal and other large needles. Hand sharpening is not successful because the bevel cannot be maintained and the cost becomes prohibitive. Needles should be cleaned properly and when sharpening the exactly correct grade of stone or wheel must be used.

Containers and pans require only a few considerations other than avoidance of mechanical abuse such as denting, and outright loss. One is that these containers should be adequately marked with an electric marking device, or with steel stamps or diamond-pointed, inexpensive marking pencils ($3.00 to $4.00). Even the best stainless steel is only partially resistive to solutions containing the salts of heavy materials, and especially when inorganically combined. The most common of these are the mercury, especially bichloride, solutions. Manufacturers recommend that the contacts not exceed four hours. This makes it obvious that a certain amount of damage is done even in four hours, and use of this equipment should be governed accordingly.

Instruments face their greatest hazard, except in the operating room, in theft or other loss. All such instruments should be carefully marked with name of the institution and the nursing unit therein. They should be kept adjusted and sharpened, and anyone found abusing them should be spoken to seriously.

*Syringes*

Much might be written about syringes, but the following viewpoints are always worthy of review.

Syringes should be purchased under specifications which call for polaroscopic testing to see if there are residual strains in the glassware because of improper and incomplete annealing. Syringes tested this way are available and justify the highest cost.

The next important specification is that the syringes be of sufficiently hard glass and so well ground that continued sterilization and application will not cause the tip to corrode rapidly or crumble away. Unquestionably this is the largest single cause of syringe failure, other than fracture. If the tips are of poor quality, the same condition of the glassware will be illustrated by leakage between the plunger and the cylinder wall.

Maintenance of syringes is much more practicable if the buying has been sound. A plunger remover, available for a few dollars, is a piece of apparatus which should be in every hospital. Syringes which have their plungers stuck for any reason are usually destroyed in attempting to separate the parts, unless a simple, effective and inexpensive instrument is used. This is similar to a syringe and permits pressure to be applied inside the stuck syringe.

Formerly, boiling of syringes was the most common cause of their erosion and pigment loss. With improved glassware, this is now less common than breakage in the hands of the user. Probably the most common breakage accident follows the laying of a syringe on the table. It rolls off, is brushed off, or is crushed while hidden in the folds of a towel.

*Thermometers*

The purchase cost and accuracy of thermometers varies, but regardless of quality there are two useful considerations to be made in purchasing thermometers so that their life will be materially expanded. In recent years, the squat or round bulb type has saved a tremendous amount of breakage in oral thermometers. A fairly recent additional improvement is that of placing on the head of the thermometer a little square or triangular piece of glass. This satisfactorily prevents the thermometer from rolling on the floor.

*Oxygen Conservation*

Oxygen is very frequently wasted when being administered to therapeutic patients. James Hamilton at the New Haven Hospital reports that a large cylinder of oxygen will run from one to two days when proper apparatus is used. In the average hospital, consumption is from two to six times this amount, and when the person is charged from $3.00 to $8.00 a cylinder, it is an unnecessary cost. The correct type of gauges and maintenance to keep them in working order are fundamental. Next is adjustment to get the needed flow of oxygen, which has to be determined solely by analysis of the mixture which the patient breathes. It is reported that there is a wide difference in efficiency among various masks, hoods and oxygen tents.

*Rubber Goods*

Volumes could be written on conservation of rubber goods, but the following constitute some lesser known of the important considerations.

Considerable waste can be avoided by cutting rubber tubing to the optimum rather than the maximum useful length for any given technique on instrument setup. For example, some hospitals provide five feet of tubing for intravenous sets, and have

*(Concluded on page 94)*

*, From an article in "Hospitals" by John Gorrell, M.D., Assistant Director, Massachusetts General Hospital, Boston.*

# ALL TYPES OF KITCHEN EQUIPMENT

**Pass your kitchen problems on to us. It is our business to advise you on the most efficient equipment for any kitchen, large or small. We can manufacture equipment to meet your specific problem. Perhaps it is a special sink and drain board, maybe twin urns with unusual capacity, perchance you may need larger working surfaces for baking or serving. Any of these problems are part of our every day work and it is a pleasure to help solve your special needs.**

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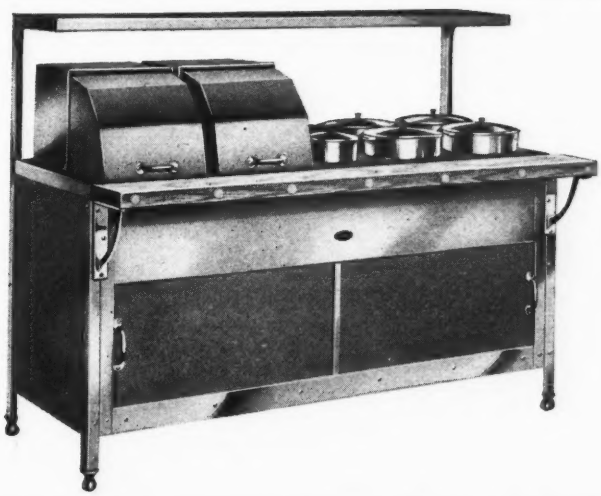

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# Deadline Set for Examination Requirements for Laboratory Technicians

UNTIL July 1st, 1945, the Canadian Society of Laboratory Technologists will admit to the examinations for general membership candidates who have adequate educational requirements but who have not graduated from approved schools for laboratory technicians. After that date only graduates of approved schools may be admitted to the C.S.L.T. examinations for general membership.

This agreement was reached at a meeting on February 9th of officers of the C.S.L.T. with the Committee on the Approval of Schools for Laboratory Technicians of the Canadian Medical Association. This arrangement was agreed upon to permit technicians now engaged in laboratory work who have had excellent training but have not graduated from the more recently organized approved schools to take out membership in the Society.

### Specialty Certificates

A somewhat similar arrangement was made with respect to those men and women doing highly specialized work in the laboratory field and who would be desirous of holding a specialty certificate. The present requirements of the C.S.L.T., made in conformity with the recommendations of the C.M.A. committee for the approval of schools call for one year of training in general laboratory work before taking training in a special field, such as serology, bacteriology, haematology, etc. At the present time there are a large number of technicians doing highly specialized work who went directly into that field from high school or university and have not taken any general work. In view of the fact that it is quite possible in the next few years, particularly if health insurance is introduced, that all laboratories doing diagnostic or other laboratory work be required to employ only technicians who have taken approved courses of training or hold certificates of membership in a recognized technicians' society, it has seemed desirable to waive the clause requiring preliminary general training and permit technicians practising specialties to take their examinations in their respective fields.

Accordingly it has been arranged that up to July 1st, 1945, technicians engaged in special fields in medical laboratory work *as of January 1st, 1944* may be admitted to the Canadian Society of Laboratory Technologists upon examination in their particular specialty *without requirement of one year of general laboratory training.* After that date one year of general training in an approved school will be required.

It is to be noted that the above arrangement applies only to those who were engaged in special fields of medical laboratory work on January 1st of this year. This special arrangement would not apply to those who take up specialty work between that date and July 1st, 1945.

### C.S.L.T. a Recognized Registry

For several years the Canadian Society of Laboratory Technologists has been recognized as a registry of laboratory technicians by the Canadian Medical Association. Several years ago, in order to have some yardstick of approval of the training of laboratory technicians, particularly when employed in smaller hospitals, the C.M.A. through a committee of pathologists and bio-chemists working with the Department of Hospital Service, set up standards for the approval of schools for laboratory technicians.

At that time the keeping of a registry of qualified technicians by the C.M.A. was considered. However, it was decided by mutual agreement with the C.S.L.T. that the C.M.A. recognize them as the official registry.

### Approved Schools

During the past three years a number of schools for training laboratory technicians have been approved by the C.M.A. Committee. Those approved to date are listed below:

* * * *

## Approved Schools for Laboratory Technicians

**Victoria General Hospital,**
Halifax.
Ralph Smith, M.D., Director.
Courses: (a) General Certificate.
(b) Specialties — Bacteriology, Haematology, Pathological Chemistry and Histology.

**Saint John General Hospital,**
Arnold Branch, M.D., Director.
Course: General Certificate.

**Hotel Dieu de Montreal,**
Georges Baril, M.D., Director.
Course: General Certificate.

**Hôpital Saint Luc,**
Montreal.
Armand Frappier, M.D., Director.
Course: Specialty — Bacteriology, Serology.

**Hôpital Saint Justine,**
Montreal.
Professor Pierre Masson, Director.
Course: General Certificate.

**St. Vincent de Paul Hospital,**
Sherbrooke.
Jacques Olivier, M.D., Director.
Course: General Certificate.

**Ottawa Civic Hospital,**
Max O. Klotz, M.D., Director.
Courses. (a) General Certificate.
(b) Specialties—Biochemistry and Haematology.

**Kingston General Hospital,**
James Miller, M.D., Director.
Courses. (a) General Certificate.
(b) Specialties — Bacteriology, Histology, Biochemistry.

**St. Michael's Hospital,**
Toronto.
William Magner, M.D., Director.
Courses: (a) General Certificate.
(b) Specialties — Bacteriology, Histology, Biochemistry.

**Toronto Western Hospital,**
George Shanks, M.D., Director.
Courses: (a) General Certificate.
(b) Specialties — Bacteriology, Histology.

**Toronto General Hospital,**
William Robinson, M.D., Director.
Course: General Certificate.

**Hamilton General Hospital,**
William J. Deadman, M.D., Director.
Course: General Certificate.

**Mountain Sanatorium,**
Hamilton.
A. R. Armstrong, M.D., Director.
Course: General Certificate

**Victoria Hospital,**
London, Ontario.
E. M. Watson, M.D., Director.
Courses: 1. General Certificate.
2. Specialties — (a) histological technique, (b) bacteriology, (c) haematology, (d) pathological chemistry.

*(Concluded on page 90)*

# New Hospital Regulations Approved in Saskatchewan

THE regulations under the Hospitals Act of Saskatchewan have been thoroughly revised and were gazetted on January 24th. Quite a number of the sections have been revised and new sections have been added.

The sections dealing with site, construction and alterations to buildings have been brought up to date. The section on fire precautions has also been revised. The sections dealing with hospital basements now require them to be ratproof and moisture-proof. The use of basement rooms is left to the discretion of the Minister.

Under the "Preparation of Food" three new sections have been added. "Pasteurized milk shall be used exclusively for patients and staff in all hospitals located where pasteurized milk is available." Utensils used in serving and preparing food shall be sterilized after use, either by means of boiling water, by chlorine solution or by live steam. All rooms wherein food is stored or prepared are now subject to definite requirements.

Every hospital shall provide a suitable nursery for the acommodation and care of newborn infants. The attending physician shall report to the superintendent any actual or suspected case of puerperal sepsis. The superintendent shall then arrange for the isolation of such patient and investigate the circumstances. The registration of all births in hospitals is made compulsory.

Under "Hospital Management" the duties and responsibilities of the hospital board have been clarified. The Advisory Medical Committee is now charged with the investigation of emergency admissions and the discharge of incurable or prolonged cases.

The medical history and provisional diagnosis must be written within 72 hours of admission and the Board is held responsible for the preparation of a complete medical record. All orders for treatment must be written and signed by a medical practitioner.

As for operations, strict rules are drawn up respecting written consent, written pre-operative diagnosis, complete O.R. report, report by anaesthetist, consultation before cases of abortion and compulsory despatch to a laboratory of all tissues removed at operation or curettage.

All hospitals must give their employees a complete medical examination at the commencement of their duties and at least once a year thereafter. It also outlines a programme to be followed by hospitals in respect to the testing and immunization of their staff for tuberculosis, smallpox, typhoid fever, diphtheria and scarlet fever.

All hospitals are required to compile a complete schedule of the hospital's charges, a copy of which shall be filed with the deputy minister. A new section (Section 58) states that no grant is payable for tuberculosis patients receiving treatment under the S.A.E.L., outdoor patients, patients whose case records are not complete, Indian patients who are wards of the Department of Indian Affairs, and patients for whose maintenance the Department of Pensions and National Health is liable.

**Orderlies Sorting Washing**

*This interesting mural painting of a hospital scene forms a panel in the Oratory of All Souls at Burghclere, Berkshire. The painting is by the noted British artist, Stanley Spencer, whose striking landscape work and unusual figure studies have been features of exhibitions in Great Britain and elsewhere for many years.*

*Photograph courtesy of "The Studio", published in London, England.*

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# Some Aspects of a Pension Plan

By OTHO BALL, M.D.
and ROBERT F. SPINDELL

*This article has been condensed from three articles published in Modern Hospital, (Nov., Dec. 1943, Jan. 1944) by Hospital Abstract Service.*

FOR a long time trustees and superintendents have recognized the need for a re-appraisal of hospital compensation plans. The question has become more acute as a result of the loss of experienced employees to the armed services and to war industries, and the difficulty of securing suitable new employees.

In times past many hospital employees have been motivated by an unselfish Christian desire for service to others in distress and have remained in hospital service despite lower wage levels. But the increased cost of living and the increases in wage levels in other vocations are tempting even the most devoted.

Likewise there seems to be a gradual decrease in the spiritual and an increase in the material motives.

To meet this development and to ensure the hospital an adequate and efficient staff, it is questionable if mere increases in salaries are likely to prove adequate. Further inducement in the form of an attractive pension plan would seem to be desirable. Even before the passage of the Social Security Act large employers found it desirable to establish various forms of pension plans, and since the passage of that Act the growth of both public and private pension plans has been amazing.

Hospitals as charitable institutions are not included under the Social Security Act, although it is now expected that they soon will be.

But even when they are so included, the operation of these plans frees the employee from the necessity of providing for a retirement income and thus in effect increases even a low income by permitting the employee to spend all instead of just a part, for his current needs. This relief from anxiety over the future is even more vital to women than to men.

Most of the pension plans, in quasi-public institutions such as hospitals are contributory but the trend today is more toward a larger share or all of the contribution to be made by the employer.

A study of figures required by a pension plan reveals that the cost, while substantial, is not too large and that it achieves considerably more benefit than can be expected from a comparable increase in compensation in any other form.

One of the results from private pension plans is definitely improved morale of employees. They lose the fear for their economic security in their old age and their appreciation of their employer's efforts engenders increased loyalty and increased effort.

### Improves Morale of Employees

Progress demands that the older men and women—superannuated employees—be replaced by younger workers, and a pension plan makes it much easier to let the older employees go to enjoy the remainder of their lives in leisure. Also it encourages the younger men by accelerating opportunities for promotion.

Likewise it helps attract competent workers. One well known business concern reports that 80 out of every 100 applicants now inquire if the company has a pension plan whereas only 12 out of 100 made a similar inquiry a year ago.

No one plan will fit the conditions of every hospital, but for illustrative purposes different types of plans are described and illustrated by their application to a typical medium-sized voluntary hospital having 125 beds and 35 bassinets and during 1942 an average census of 110 and an average of 53 employees.

The basis for determining eligibility to a pension plan is length of service. The Internal Revenue Code gives automatic approval to a plan which fixes a minimum of 5 years service for eligibility to a pension plan. But most business concerns prefer a shorter period—2 to 3 years—as this shorter period provides more incentive to employees than the longer period. A plan can be adopted which limits participation to certain groups of employees but one overall plan covering all employees on a basis of years of service will usually be more acceptable and more effective. It is usually provided that time spent in the Armed Service shall be included in the reckoning of length of service for eligibility purposes.

In the typical plan here considered the retirement income amounts to 20 per cent of monthly compensation though it is sometimes necessary or desirable to fix a maximum of $120, $200 or $300 per month for the more highly paid employees.

In determining the amount of pension, the value of maintenance given the employee should be included as compensation. The monthly figures used in this typical plan are: breakfast, $10.00; lunch, $12.50; dinner, $15.00; room, $12.50; laundry, $5.00; a total of $55.00.

The reason for selecting 20 per cent of the compensation as the retirement income is that hospitals are likely to be brought under the Social Security Act in the relatively near future, and that will provide for most employees a pension of 20 to 25 per cent of their compensation. This added to the regular pension will then provide a total retirement income of between 40 and 45 per cent of the employees' compensation.

In this typical plan the amount received by the majority of pensioners ranges from $20 to $40 per month—only two receiving more than $50. The most important factor in any plan is determination of the amount of pension to be given and this will in general depend upon the location of the community and community wage scales, and size and financial position of the hospital. Also the question of a death benefit and of forfeiture or vesting of employee's equity in case of separation from the service enters into consideration.

The retirement age is usually set at 65 years, though some provide for retiring women at 60. In case of

*(Continued on page 78)*

## Pension Plan

*(Continued from page 76)*

employees over 55 years of age, retirement age is generally set at 10 years after date of eligibility. This works out surprisingly well, whereas a shorter period would likely be unduly expensive.

The hospital may reserve the right to lower retirement age with proportionate reduction in the amount of pension. Also an employee may be permitted to work beyond 65 and still receive his pension, but it is taken into account in fixing his compensation.

When employee reaches retirement age he receives his pension monthly for life but may, by taking a lesser amount, provide for continuance through the life of surviving spouse or other joint beneficiary. In such case he may be permitted to change beneficiary, who may receive the benefits either in a lump sum or in installments.

In most cases employees are much interested in the insurance feature covering death before retirement with monthly payments to beneficiary over a period of 10 years. If pension is for life of employee and spouse, payments continue until death of both.

Permanent disability is treated in a manner comparable to retirement benefits. If employee leaves the service of the hospital, for any reason other than retirement, disability or death, he receives a vested interest in the fund amounting to 30 per cent at the end of the first year after becoming eligible plus 10 per cent for each succeeding year until his interest becomes 100 per cent vested. Any amount not so vested will be forfeited and used to reduce the contribution to be made by the hospital for the other participants in the following year.

A great variety of vesting provisions is available, some based on years of service, some on years of eligibility and some on a combination of the two. Some plans provide for complete forfeiture at severance from service other than by death, disability or retirement of age.

The cost of the plan studied (based on years of eligibility) was found to be $13,500 for the first year and about $1,000 less per year thereafter. Of this amount $1,190 is used to purchase retirement benefits for 3 employees over 60 years of age. Because of the many pay roll deductions it is recommended that the hospital bear the entire cost during wartime, changing the basis later as seems desirable.

Retrievals upon resignation or dismissal of employees will help reduce the cost in future years. Also payment of death benefits to the pension fund instead of to beneficiaries will also reduce the cost substantially.

The plan is simple to administer, as the contracts are taken over by standard insurance companies.

The cost would be about 25 per cent less if under a group annuity plan with complete forfeiture in case of death, dismissal or resignation.

### Safeguard Hospital's Interests

Trustees should reserve the right to terminate the plan at any time, and the participants could then continue under individual contracts with the insurance company. Also provision should be made to prevent the employee assigning his interest in the trust and to prevent creditors from reaching it.

The type of plan discussed previously includes all employees of two years or more of service, provides a pension of 20 per cent of monthly compensation (including allowance for maintenance), commences at age 65 for most participants and provides substantial death benefits both before and after retirement.

For the 53 employees included, the first year cost of the plan is about $13,500 and is funded by individual retirement endowment contracts. It is administered by 3 trustees of a pension trust appointed by the hospital board of trustees. This is referred to as Plan 1.

A very different type of plan is the group annuity referred to as Plan 2. The amount of pension is based on years of service already rendered and amount to be rendered between now and retirement age. Retirement age is 65, except that for employees now between 55 and 60 it will be 10 years from date of participation in the plan. For those past 60 retirement age would be 70. The amount of future service annuity will be 1.5% of current monthly compensation multiplied by number of years between now and normal retirement age. Amount of past service annuity will be 1 per cent of current monthly compensation multiplied by years of service after he reached 40 years of age.

Thus an employee aged 45 and in the service 5 or more years would have a pension at age 65 as follows:

1. Future service annuity ..... $20 \times 1.5\% = 30\%$
2. Past service annuity ..... $5 \times 1\ \% = 5\%$

As employee's compensation increases, amount of future service annuity will increase; assuming for instance that his compensation had been $2,800 per year for the past 5 years, and continues at $2,800 for 5 years more and then at $3,200 for the next 15 years up to retirement age, his pension would be:

1. Future service—$7.5\%$ $(5 \times 1.5)$ of $\$2,800 + 22.5\%$ $(15 \times 1.5)$ of $\$3,200 = \$930$.
2. Past service—$5\%$ $(5 \times 1)$ of $\$2,800 = \$140$. Total $1,070—

or about 33 per cent of his final salary.

Under Plan 1, death before retirement would entitle each insurable employee to $1,000 life insurance for each $10 unit of retirement income, and each insurable employee a death benefit equal to the total premium paid.

Under the group annuity Plan 2 there is no death benefit before retirement, except a return of all employee's own contribution plus 2 per cent compound interest thereon.

Under Plan 1 benefits for death after retirement are at least 120 monthly payments. Under Plan 2 there are no death benefits and the pension ceases at death, but the heirs will receive the remainder of his own contribution plus 2 per cent interest.

Since Plan 2 does not provide for death benefits the amount of monthly pension is much greater than in Plan 1.

Under either plan the interest of an employee who resigns or is discharged may be wholly or partially vested or forfeitable, but in any case the amount of his contribution plus 2 per cent compound interest is returnable.

*(Continued on page 92)*


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## Formulation of Rat Baits

FIRST of all a rat bait must be so palatable as to tempt him to eat it in preference to other available foods. It must contain enough of the toxic agent to destroy rats eating relatively small amounts. It should remain attractive long enough for suspicious animals to overcome their suspicion and have enough odour to draw rats to the less attractively placed bait spots.

The poison situation is now reported to be slowly improving. Supplies of strychnine, arsenic, zinc phosphide, barium carbonate and phosphorous combinations are assured. Limited red squill shipments are coming from North Africa. There is little hope of any material supply of thallium until foreign imports are established. Some of the less well known chemical poisons are available, but they are not of much value as they are not well accepted in any bait combination so far devised. Some of the newer synthetic organic chemicals are very promising.

Although rats will eat all of the three major food types, proteins, fats or carbohydrates, food rationing has so limited availability that search has been made for suitable baits of non-rationed foods.

Horse meat hamburger has been a satisfactory substitute for beef hamburger. It has been satisfactory mixed with 10 per cent fortified red squill powder, 2/3 per cent white arsenic, 1½ per cent thallium, 1 per cent zinc phosphide and ½-1 per cent of the newer research poisons.

Such a bait is very perishable and must therefore be freely prepared. A mixture of 50-75 per cent meat and 25-50 per cent bread crumbs, cracker crumbs, cornmeal or oatmeal seems to be accepted quite as well as 100 per cent meat and will remain fresh for a much longer time.

Such vegetable proteins as "soy bean lecithin" are attractive to rats so long as they are not rancid. One good formula is ½ lb. of tank settlings mixed with ½ lb. mineral oil to a smooth solution, add 1 lb. fortified red squill powder and then 8 lbs. of cracker or bread crumbs. Peanut butter is another good bait. Fresh fish used like the horse meat is a good bait. Grind 2 lbs. of fresh fish, add 7 lbs. of poultry, rolled oats or cracker crumbs and 1 lb. of fortified red squill. Cereal is added to make the bait last longer, and the amount may be adjusted according to conditions. If available, pork fat is a good substitute for the fresh fish in the above formula.

Fish oils are useful as a lure but must not exceed 5 per cent of the compound. Peanut oil is not as good as peanut butter, and soy bean oil is not as good as the soy bean lecithin. Raw linseed oils 3-5 per cent has given good results.

Most fresh vegetables used under proper conditions make highly attractive baits and are easily available.

White bread is good bait but rats prefer the pre-war rather than the present day modified types.

The practice of pre-baiting will pay dividends, particularly if it is necessary to use some of the less attractive baits.

*(Condensed from an article by Justus C. Ward in "Soap and Sanitary Chemicals" by the Hospital Abstract Service.)*

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**Saint John General Women's Hospital Aid Hold 25th Annual Meeting**

The Saint John General Women's Hospital Aid held its 25th annual meeting on February 17th. Mrs. Percy N. Woodley was re-elected president by acclamation. The aid year closed with a membership of 1,301 and its expenditures for gifts for patients approached the $700 mark. Mrs. C. H. Wiley, treasurer, reported general receipts of $5,382.-51, which included bequests from J. N. Noble for $1,761.40 and from F. W. Noble for $2,652.75.


**Mosquitoes Mean Malaria!**

*Signs like these have helped to keep the incidence of malaria among Canada's Mediterranean troops at an amazingly low level.*

*(Cut courtesy "Canadian Pharmaceutical Journal")*

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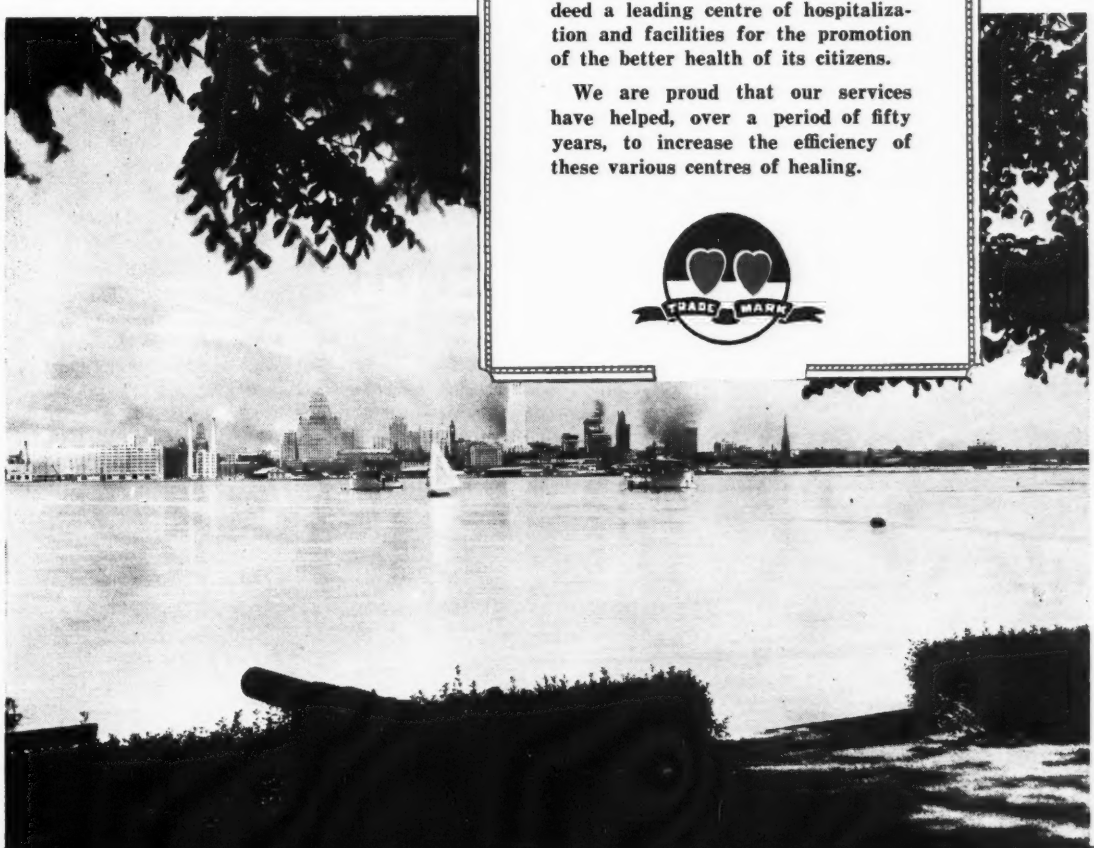
**We are proud that our services have helped, over a period of fifty years, to increase the efficiency of these various centres of healing.**



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## Health Insurance

*(Continued from page 43)*

**5. Fewer Surgeons**

A pre-requisite before any plan of medical payment can be put into force would be a listing of those doctors qualified to receive payment as specialists and consultants, or to do major surgery. The preparation of lists of specialists in the various fields has been undertaken by the Royal College of Physicians and Surgeons of Canada. As it is quite possible that payment for major surgery (probably including major operative obstetrics) may be limited to those certified as specialists, except in case of an emergency or in areas where certified specialists are not readily available, it is reasonable to anticipate that the number of doctors doing major surgery in hospitals will be reduced materially. This would mean less major surgery in some hospitals and simplified routines on surgical wards in others.

**6. Completion of Facilities**

The gaps in our hospital system would gradually be filled in. The present measure provides that the provinces are to set up committees to see what areas are not properly served professionally and otherwise, and to recommend appropriate action. One would anticipate a more complete chain of rural hospitals, varying from reasonably-well equipped institutions in country centres to nursing outposts. Patients not now well provided for, such as those suffering from communicable disease, the chronically ill, the mildly psychopathic, the convalescent, the narcotic addict and the chronic alcoholic, will probably be looked after more adequately under a more co-ordinated system. We must admit that our present hospital system, although it has provided efficient services to the vast majority of the people, has lacked unified direction in its development and has left some serious gaps in its coverage.

**7. Closer Supervision**

Inasmuch as public funds will constitute the major portion of operational income, it is but to be expected that any health insurance commission set up will exercise close supervision of hospital methods and expenses in general. If the Commission can be kept non-political, as hoped, with the hospitals themselves adequately represented thereon, this likelihood should not be deplored; in fact it should help a great deal to hold and increase public confidence in hospital management.

**8. Unnecessary Expansion**

Again, inasmuch as public funds are involved, it is conceivable that payments for operational expenditure may be refused where the Commission considers any expansion made to be quite unnecessary, when such produces needless duplication of services, or where other types of ex-

*(Continued on page 84)*

# Sap's Runnin'!

*Now is the time to enjoy a day in the sugar bush. Down our way we noted sap running on February 6th—another effect of the mild winter. No, these pictures were taken last spring. Left: A visitor samples the sap. Right: Fires under evaporating pans in the sugar house are kept burning night and day.*

# "Vitrolite" IN HOSPITALS

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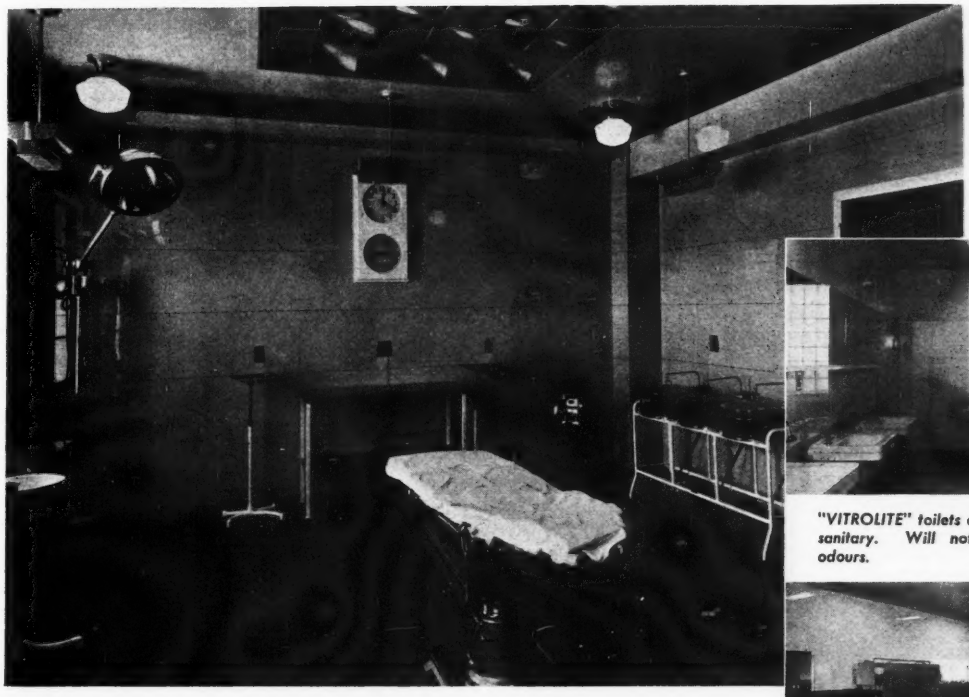
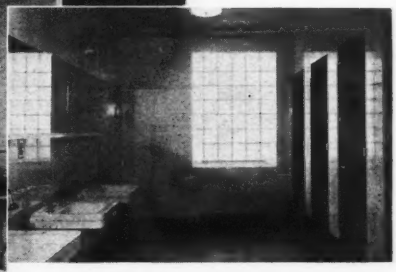


*Operating room in Shaughnessy Military Hospital, Vancouver, B.C. Mercer and. Mercer, Architects.*



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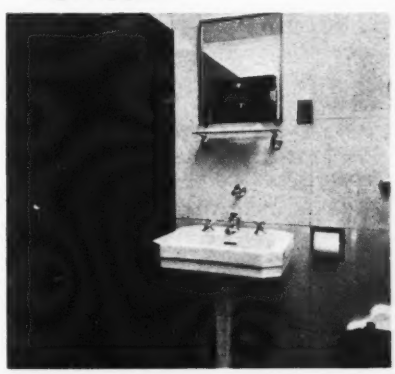

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## Health Insurance

*(Continued from page 82)*

pansion are more urgently needed. If wisely and impartially rendered, such actions may be distinctly in the public good and a protection to hospitals already carrying on efficient services. It is absolutely vital, however, that any such restriction of initiative, voluntary or municipal, should be fully warranted and be completely free of bias or political pressure. This is not easy to maintain.

**9. Public Health Participation**

Present indications are that any health insurance legislation of a general nature passed in Canada will lay much emphasis upon public health and preventive medicine. Mention has been made already of the possibility of diagnostic units being established. One would anticipate that many hospitals may find themselves broadening their activities to include a wide range of public health functions. This may be especially true of hospitals in smaller towns and rural areas. Public health nurses and regional laboratories may be housed in the hospital and extensive social service and mental hygiene activities may centre there. This possibility should be borne in mind in any future expansion.

**10. Controversies with Municipalities**

If patients unable to pay are to be included under a health insurance measure, the protracted controversies with municipalities over "residency", or as to who is, or is not, an indigent, should become struggles of the past. It would still be necessary for those unable to make contributions to prove such to the authorities, but the hospitals would not be involved in these details.

**11. Private or Proprietary Hospitals**

The present measure does not provide for the inclusion of proprietary hospitals "except as may otherwise be prescribed", presumably in those instances where a public hospital, municipal or voluntary, is not located in the area. Many of these hospitals have given excellent service to their communities, and their exclusion will cause some personal hardship. Nevertheless, with very few exceptions they suffer from one fundamental defect—namely, that there is very little, if any, adequate supervision of the medical work done therein. Very few have acceptable medical staff organization. Their facilities and equipment are limited as a rule and provincial supervision has been largely with respect to sanitation and fire protection. In Canada there are 245 proprietary hospitals or nursing homes with an average capacity of 12 beds. Unlike in the United States, the great majority of proprietary hospitals in Canada are operated by nurse-proprietors, not by medical clinics or individual surgeons.

**12. Effect on Medical Staffs**

With all patients on a paying basis it would be reasonable to anticipate some demand by the medical profession at large to "open up" the wards in "closed" hospitals. The anticipated decision not to recognize proprietary hospitals will prevent a deflection of many ward patients to such hospitals. If the medical profession be paid on a fee-for-service basis, this demand will be more general than if doctors be paid on a capitation basis; in the latter instance there would be no financial incentive to retain the patient and, as in Great Britain, many practitioners would be content to turn over many of their hospitalized patients to a hospital staff. Under certain conditions it may be desirable for hospitals with closed general wards to establish certain "open" semi-public beds.

Medical attendance on private and semi-private wards may be very much as it is now. The proposed measure would leave the decision with respect to staffing policy to the individual hospital. This provision has been urged by the Canadian Hospital Council, for some measure of control by the hospital board and the medical staff has long been recognized as in the best interests of the patients.

If all patients be "paying" patients, there may be some lessening of the *legal responsibility* of the hospital and its medical staff for the care of patients. This would apply particularly in those cases where the former indigent, instead of having to accept the doctor named by the hospital, would now have the right, in open hospitals, to select his own doctor.

The differentiation between the attending or active staff and the courtesy staff may be reduced, particularly in open hospitals. On the other hand the disciplinary committee of a staff may find itself requested by the Commission, or the medical committee advising such Commission, to take a greater measure of oversight over the medical care on the private wards than has been customary in the past. Any laxity of supervision which permits improper treatment, thus prolonging hospitalization and increasing costs to the central Fund, becomes a matter of concern to those administering the Fund.

**13. Effect on Medical Schools**

One of the most serious effects of general health insurance may be on the medical schools. If all patients are to be private patients, who will be available for clinical observation? If the patronage of outpatient departments dwindles or ceases, that valuable avenue for clinical experience will be lost. The medical schools are very much concerned over the possibility of an ultimate serious effect upon the quality of medical teaching.

Various solutions have been proposed. If diagnostic clinics replace outpatient departments, they should be set up in teaching hospitals in centres where there are medical schools. The Canadian Medical Association has recommended that *all* patients under the plan be available for clinical observation if so required. This would answer the criticism of certain labour spokesmen who have resented the wording in an earlier draft of the measure that patients coming under the Act, other than private or semi-private patients, would be available for teaching. It has been suggested that teaching hospitals receive added remuneration so that hospitalization therein could be made more attractive to patients. The Canadian Association of Medical Colleges has added its voice to those who favour the capitation method of payment of doctors, inasmuch as practitioners would then be more willing to have their hospitalized patients come under the teaching staff.

There are others who do not fear extensive reductions in the number of patients available for teaching. They take the view that the high

*(Concluded on page 86)*

# 3.25 A.M. 'Twas ever thus—

## No---Not a Call To a Confinement

Mrs. Jones took the hypnotic you prescribed at 11 P.M., and is now awake again. She has been spending the past hour wondering whether or not she should take another. What are you going to tell her? For your own sake say, "Yes". What if she does have a "hangover" until noon? Tomorrow you can prescribe **Prolonotic Tablets,** and with their timed disintegration they will automatically release a *second* dose, *while she still sleeps.* Mrs. Jones will get a full eight hours sleep—and what's more, so will you!

**Prolonotic Tablets** each contain TWO SEPARATE doses totalling 1½ grains of Sodium Phenobarbital. The initial dose of one-half this amount is released for immediate absorption, the second half does not become therapeutically active until four hours have elapsed. A full night's rest is thereby assured the patient.

***Prolonotic Tablets are exclusively an Anglo-Canadian achievement***

*—Please write for clinical trial packages—*

**Anglo-CANADIAN DRUG Company**
OSHAWA CANADA

*One hundred per cent Canadian*

MANUFACTURERS OF FINE PHARMACEUTICALS

KEEP BUYING WAR BONDS AND STAMPS AND WE WILL ALL SLEEP BETTER

## Health Insurance

*(Concluded from page 84)*

quality of service associated with teaching hospitals will ensure for them continued patronage. Be that as it may, both the medical and hospital spokesmen have urged upon the parliamentary committee the vital importance, from the standpoint of future generations, of ensuring competent medical teaching.

**14. Closer Co-operation Between Hospitals**

In view of the obvious desire of any administrative authority to obtain maximum efficiency for the funds expended, we could anticipate a movement towards greater co-operation between individual hospitals. In larger centres some specialization of activities in certain general fields might occur, within limits. There might be closer co-operation between rural hospitals and urban hospitals, particularly with respect to the transfer of patients, the utilization of specialists and, in some cases, the lending of equipment. The extent to which this would occur would depend in large measure upon the basis upon which general practitioners and specialists would be paid, a transfer of patients for special treatment being less likely under a fee for-service basis.

**15. Effect on Philanthropy**

What about the effect of health insurance on philanthropy? Will it stifle voluntary support? That is feared by many and may happen if the situation is not carefully handled. Certainly the incentive to help the indigent patient will be gone. However, health insurance does not necessarily need to undermine the support of philanthropy.

The proposed measure would only provide payments for patient care in general hospitals. Capital construction costs would be assisted only in the case of tuberculosis and mental institutions — and, we would infer from one section of the measure, in sparsely-settled regions where small hospitals are badly needed. This would still leave the broad field of capital construction for private or municipal endeavour. There would always remain, also, the field of personal service to the patients, such as social service activities, hospital library work, etc.

In many respects philanthropy might increase. This is suggested because philanthropy that discriminates —and more of it does to-day—is more likely to consider hospitals worthy of support if donors can be certain that every cent of their contribution is being used wisely, without unnecessary duplication and to the greatest possible public benefit. One would feel that the greater danger to philanthropy would come, not from health insurance *per se* but from the likely-to-be-continued high taxes, the general dissolution of large fortunes and, perhaps, the loss of public spirit by hitherto generous and altruistic citizens because of the short-visioned actions of certain over-militant group leaders.

One anticipates that the future will evolve a *partnership of state and voluntary effort*—an era in which we shall develop a new conception of personal responsibility, that of responsibility to the state, or society as a whole. State and voluntary effort should supplement each other and the outcome should be the development of advances not now possible, combined with a retention of the many fine features of our present system —traditional features that have more than proved their value over the years and should not be lightly discarded.

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### Medical College Planned for University of Saskatchewan

The Government of Saskatchewan has authorized the Governors of the University of Saskatchewan in Saskatoon to proceed with the preparation of plans for the construction of a medical college at the University. However, Premier W. J. Patterson stated that the actual construction would have to wait until materials and equipment would be available.

At the present time the University of Saskatchewan offers a pre-medical course for students from the province who wish to take their groundwork in Saskatchewan. They then go to medical schools in other provinces to complete their medical course. With the possibility of health insurance, the number of medical graduates who will be needed will be greatly increased and more medical schools will be needed. The provision of the necessary clinical and hospital facilities in Saskatoon is now under consideration.

### THE TEN LEADING CAUSES OF DEATH

(as compiled by the Dominion Government)

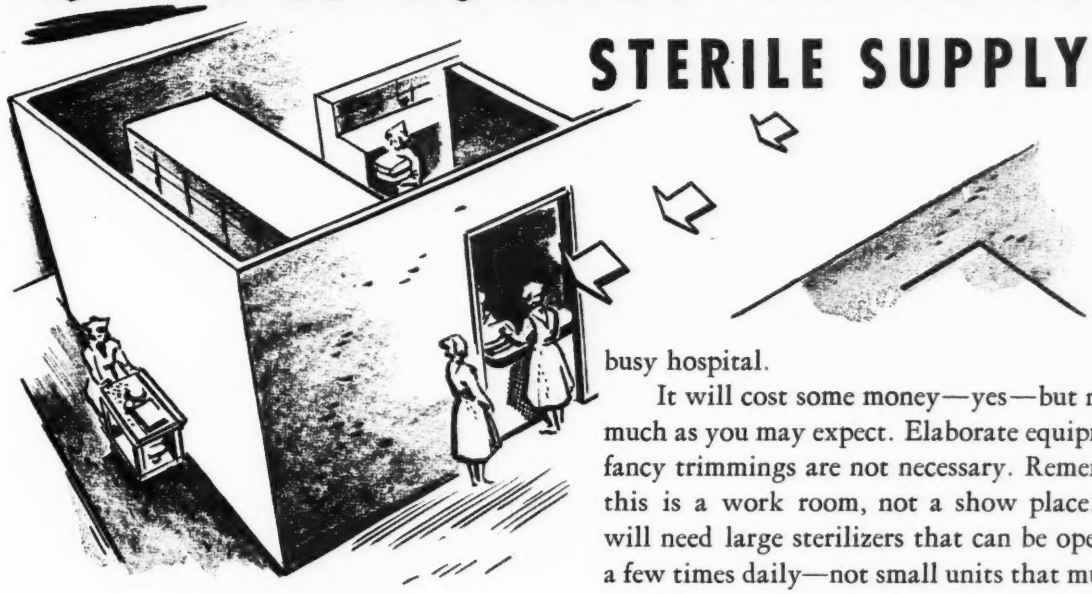
| Rating — 1942 | No. of Deaths | Rating Ten Years Earlier (1933) |
|---|---|---|
| 1. Diseases of Heart | 27,506 | 1 |
| 2. Cancer (all forms) | 13,643 | 2 |
| 3. Accidental or violent death | 8,127 | 7 |
| 4. Nephritis | 7,222 | 8 |
| 5. Diseases of Arteries | 6,511 | 4 |
| 6. Diseases Peculiar to First Year of Life | 6,020 | 3 |
| 7. Tuberculosis (all forms) | 5,991 | 5 |
| 8. Pneumonia (all forms) | 5,771 | 6 |
| 9. Intracranial lesions of vascular origin | 4,467 | 10 |
| 10. Influenza (all forms) | 1,219 | 9 |

### Facing Facts

Anyone who faces facts bluntly, as the war demands we do, will come to these conclusions: that the task of apportioning and placing our limited supply of physicians where they are most needed must be a national task; that national action to meet these needs is urgent because good medical care is vital to war production and popular morale; and that the Pollyanna attitude which minimizes such needs in favour of medicine-as-usual is a disservice to the nation's efforts in this war.

—From "Medical Care", Nov., 1942.

# More about that CENTRALIZED STERILE SUPPLY



Never before in the history of hospitals has there been the imperative need that now exists —for the well organized, efficiently managed, comprehensive Centralized Sterile Supply.

Why? Because with the present (and growing) shortage of nurses it has become necessary to employ unskilled personnel. In sterilization, this can be done safely only when the details of preparing goods, loading the sterilizers and operating them is strictly and continuously supervised by an individual well grounded in the fundamentals—and whose sole business it is to manage the work.

Divorce this highly important supervision from the duties of the already over-worked Operating Room Supervisor. Provide that thorough-going supervision for your Central Sterile Supply, build up stocks of sterile supplies and maintain them. Be ready for those emergencies when they occur—with certainty that nothing has been neglected.

It can be done, it has been done even under the present emergency conditions. Those who have organized Central Sterile Supplies will be the first to advocate this system as a "must" in the operation of any busy hospital.

It will cost some money—yes—but not as much as you may expect. Elaborate equipment, fancy trimmings are not necessary. Remember, this is a work room, not a show place. You will need large sterilizers that can be operated a few times daily—not small units that must be operated continuously; one or two adequate sinks for the clean-up section; perhaps a water still; good work tables and plenty of storage space for sterile and unsterile supplies.

Arrange your space most carefully to provide for continuity of movement of supplies through the department—to avoid confusion and unnecessary work. Doors should be of the dutch type, half length, to prevent entrance of all outside personnel.

We can help you to develop and organize such a department. Do not worry too much about the location if it is not entirely central. The most important thing is organization and management. Some of the most successful Central Sterile Supplies are remote from the center of the hospital, often in the basement of the building.

*★ Ask for our literature on the general subject and permit us to help you with your plans. Address your inquiries to Department of Research, American Sterilizer Company, Erie, Pa.*

**AMERICAN STERILIZER COMPANY • Erie, Pa.**

# Organization for Epidemics

AT the Conference on Epidemics in December, where representatives of a number of national organizations convened at the request of the Canadian Medical Association Committee on Epidemics, approval was given to the following basis as the best method of organizing a programme of action in each province.

**Basis of Provincial Organization**

1. Each urban or rural area throughout the province should be a unit of organization.

2. List all doctors and nurses available.

3. The Victorian Order of Nurses and other similar nursing organization will be invaluable in many localities as centres for organization of the Nursing Services.

4. List all trained nurses outside of active nurses (retired, married, etc.), all so-called practical nurses, and others willing to take duty, whole or part-time, in case of emergency.

5. List all trained help such as St. John Ambulance Home Nursing Divisions, V.A.D.'s, Voluntary Nursing Aides, Stretcher Bearers and Red Cross workers available.

6. List all other essential helpers available and study the amount of additional training that could be given them.

7. List all automobiles, drivers and helpers available for transportation of supplies, fuel, food and medicines, patients to hospital, nurses to points of duty, etc.

8. Make a survey of buildings that could be used for emergency hospitals: of beds, cots, bedding, cooking equipment, etc., that might be made available.

9. Organize patrols to visit every home to search out those where all are sick and unable to secure help.

10. Retain personnel and organization of Civil Defence.

11. Make a study of what the Service Clubs and other lay agencies are able and willing to do; how the Navy, Army and Air Force personnel, both professional and lay, could be used; how the Police and Fire Department personnel could be used.

12. Make a study of how radio can be used to best advantage.

13. Newspapers and pamphlets are perhaps the most effective means of distributing information to the public.

14. As epidemics spread along the lines of travel, a study should be instituted and all plans laid for curtailing travel to the absolute minimum at the earliest threat of epidemic disease.

15. The conditions of sections of the Indian population, such as malnutrition, over-crowding and exposure, render them particularly vulnerable to epidemics with attendant abnormally high death rates. Therefore we recommend that the needs of the Indian communities in the face of an epidemic be kept in mind by the Provincial Committees.

16. Committees formed to carry out all the above surveys and

*(Concluded on page 90)*

### Epidemics Conference

*(Concluded from page 88)*

studies should work in close co-operation and with complete understanding of each others duties.

17. All efforts should be conducted with the full knowledge of, and in complete harmony with, the various departments of health.

18. Frame the results of all surveys and studies into one whole co-ordinated plan of action.

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### Health Insurance

*(Concluded from page 38)*

doctors and hospitals within the patient's locality.

Mr. Mackenzie did not favour a non-contributory scheme. "Such a system encourages the pauper mentality and may create a delusion that the public purse is bottomless, thereby encouraging extravagance and maladministration. It is more consistent with the dignity and independence of many that he should purchase the necessities of life with his own money".

### Timely Features at New England Hospital Assembly

Hospital people in the Maritimes and elsewhere in Canada are invited to attend the meetings of the New England Hospital Assembly in Boston on March 15-17. The programme is being prepared by the Vice-President, Mr. O. C. Pratt, well known to hospital people here.

A feature of the programme is an "Institute for Hospital Volunteer Service". This will take place on the first day. There will also be a consultation service, to which individuals can bring their various problems. As would be expected, manpower will be one of the major items on the programme, and speakers will include Miss Mary Switzer and Miss Louise Baker of Washington and also Miss Lucille Petry, director of nurse education of the U.S. Public Health Service. Hospital financing will take up a good portion of the programme. Dr. G. H. Agnew of Toronto will discuss the "Units of Credit" system for the payment of hospital care. "Education in the Hospital" is being featured, and there will be a number of speakers, including A.H.A. Secretary George Bugbee, on the subject of "Public Relations". Mr. Frank J. Walters, A.H.A. President, will be the speaker at the President's Luncheon. All meetings are being held in the Statler Hotel. Miss Frances C. Ladd of Jamaica Plans, Mass., is President of the Assembly.

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### Laboratory Technicians

*(Concluded from page 72)*

**St. Boniface Hospital,**
James Prendergast, M.D., Director.
Course: General Certificate.

**Regina General Hospital,**
D. F. Moore, M.D., Director.
Course: General Certificate.

**Regina Grey Nun's Hospital,**
D. F. Moore, M.D., Director.
Course: General Certificate.

**Saskatoon City Hospital,**
W. S. Lindsay, M.D., Director.
Course: General Certificate.

**St. Paul's Hospital,**
W. S. Lindsay, M.D., Director.
Course: General Certificate.

## Pension Plan

*(Concluded from page 78)*

Under Plan 2 the employee may be required to contribute 4.5 per cent of his current compensation, the hospital paying the balance.

It has been common practice for the employee to contribute a part of the cost, as this is necessary in order to build up an adequate pension in case the employer can not pay the entire cost.

But under present conditions, with so many deductions from the employee's pay, most employers are adopting a plan requiring either very small or no contribution at all. The choice rests with what the hospital can afford to pay.

Under Plan 2, studied in detail for 53 employees, the employee's contribution—for future service annuities only—amounts to $5,019 while payments by the hospital amount to $7,744 for future service annuity and $2,752 for past service annuity if spread over 10 years.

If the past service contributions were spread over 19 years it would be $1,580 annually. Thus the hospital contribution for the first year might be either $10,496 or $9,624, or 26 or 24 cents per patient per day.

The total cost of Plan 2, including the 4.5 per cent contribution by employees, is $15,515 or $14,643, depending on whether the past service cost is amortized at 10 or at 19 years. If the entire cost of Plan 2 is paid by the employer the entire future service cost would be reduced from $12,673 to $11,008 because in the contributory plan, the insurance company must return the employee contributions plus interest in the case of death, whereas in the case of a non-contributory plan no such refund is made. Including past service contributions would bring the cost to the hospital at $13.760 (34 cts. per patient per day) or $12,558 (31 cts. per patient per day) depending upon 10 to 19 year amortization.

The cost of Plan 1 remains level year after year until employee dies, retires or leaves the service. Under group annuity, Plan 2, the cost increases each year because each year's contribution is in effect used to buy individual simple premium annuities based on the then attained ages of the employees, but this increase is largely offset by the new and younger replacements coming into the plan.

In the largest hospitals with more than 1,000 employees, a third plan may be used. This is a self-administered plan with benefits similar to Plan 2 under which the hospital makes its contribution to a pension trust.

In any case the entire plan should be set up by a specialist in pension trust matters with an actuary to make out the formulas.

The self-administered plan has the advantage of lesser cost, while the insurance company plan costs more but has the advantage of guaranteed pension payments.

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The hospital is one of the finest flowers of our civilization. We are the trustees of the accumulated medical knowledge of the past and shall not—we must not—fail the future. It is up to every one of us to do our part to preserve this great, perhaps the greatest, institution of a democratic society.

*Willard C. Rappleye, M.D.*

### Hospitals in Britain

*(Concluded from page 56)*

pitals providing special forms of treatment would have claims to special consideration, either from governmental or other sources of financial assistance. In this connection it is recognized that good work may be done which has no special value from a teaching point of view. It will be appreciated that these proposals are only in embryo and the report of the Committee must be available before we can know how far they have committed themselves. It will probably be some months before it is complete for publication.

### Conserving Supplies

*(Concluded from page 70)*

experimented to try to reduce this to four feet.

When tubing is sterilized, it is best to have a non-metallic spool on which it is placed to keep it from touching the hotter coils or bottom of the sterilizer. As in the sterilization of rubber gloves, metal and even glassware should not be permitted to come in contact with rubber at high temperatures. One hospital uses a square board with a series of wooden pegs circularly arranged, around which the tubing is wrapped for boiling. Occasionally one is able to find a plastic spool such as that used in developing rolls of 35 mm. films.

It is known that when rubber is heated to a high temperature, as in sterilization, the rubber becomes soft. If used immediately, it is friable, has lowered strength and is in greater danger of permanent deformity. Where it is possible to adjust the inventory and use of rubber goods, a period of not less than twelve hours should be provided, so that the rubber may recover by air cooling and self-vulcanization.

Cleanliness of the inside of rubber tubing, particularly that used for intravenous work, may mean the difference between life and death of the patient and may seriously affect the life of the tubing. A small, cylindrical, soft, wire brush drawn through rubber tubing in the presence of a weak alkaline solution accomplishes both a mechanical and a chemical cleansing.

### Price Trends

(On basis 1926 = 100)

| | Yearly Average 1942 | Jan. 1943 | Dec. 1943 | Jan. 1944 |
|---|---|---|---|---|
| Building and Construction Material | 115.2 | 118.3 | 126.5 | 126.6 |
| Consumers' Goods (Wholesale) | 95.6 | 96.1 | 97.8 | 97.8 |
| | (On basis 1935-1939=100) | | | |
| Cost of Living | 117.0 | 117.1 | 119.3 | 119.0 |

### Control Board Rulings

*(Concluded from page 64)*

the government in the forthcoming budget to recommend to the House a safeguarding measure which will ensure that in the case of any contribution by a business concern, whether corporate or otherwise, to an organization classed as a charitable organization which is subscribed after today, that is January 31, 1944, the tax advantage in respect of such contribution shall not be greater than that obtainable by a comparable business concern which is not subject to tax at the 100 per cent rate on excess profits". In other words, while permitting full allowance for donations (up to 5 per cent) from firms on the 40 per cent minimum basis, this allowance would be cut to 40 per cent of the donation from those paying 100 per cent taxes.

However, on February 18th Mr. Ilsley modified this, and we quote; "I wish to announce that the limitation of tax advantage which I proposed on January 31, 1944, will not affect any business whose total contributions in any year are not above the average of its donations in its last two fiscal years ending before July 1, 1942, which was the date when the 100 per cent excess rate came into effect. The proposed limitation which I announced on January 31 will apply, however, when contributions made are above the average established by the record of this two year period. That is, the limitation will apply to that portion of the amount of contributions not subscribed on or before January 31, 1944, which results in the total amount contributed in the tax year of the business being in excess of the average amount contributed in the last two fiscal years of the business concern ending before July 1, 1942".

The present five per cent limitation with respect to the total volume of deductions allowed will, of course, continue to operate.

* * *

#### Hard Furniture

On and after February 1, 1944, the manufacturers of hard furniture are authorized to add a surcharge of not more than 3 per cent over the lawful maximum selling price (exclusive of Sales Tax) to the price of hard furniture.

This surcharge does not apply to furniture sold to hospitals. Six classifications are exempt: office furniture, school furniture, church and lodge furniture, hospital furniture, laboratory furniture and radio cabinets.

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#### Essential Nursing

Hospitals for so long have put the emphasis on nursing service that it is difficult for them to think now in terms of essential nursing care. We continually hear of hospitals who are having to close floors because of lack of nurses, yet are using nurses as room clerks and in central supply rooms, and are still continuing to give baths to all patients every day and carrying out elaborate nursing procedures, and many other things that will need to be discontinued for the duration, if all patients in hospitals are to have essential nursing care.

*—By L. Louise Baker, P. and A. Service, War Manpower Commission, U.S.A.*

### Art in Illness

*(Concluded from page 60)*

a new "student" to appreciate the pictorial possibilities of their actual surroundings—to see the significance of such homely objects that lie within reach of their beds, but once they realize by actual demonstration what interesting arrangements can be evoked from such unpromising material, they often achieve interesting still-life groups.

Though my methods thus vary with each patient, I encourage them all to seek a personal way of expressing themselves. And notwithstanding their natural avidity for professional tips, I am loath to impart a textbook way of doing it, and only pass on such technical "asides" as will enable them to develop their ideas with greater coherence.

From time to time a talk on some famous artist is given (which is broadcast to the bed patients), and it is to their credit that the painters so far discussed include the names of Cézanne, Picasso and William Blake.

Finally might I add that while the other therapy classes devoted to the making of useful and fancy goods may well be relinquished when the patient is fit enough to leave, the germs of art appreciation, plus a certain working knowledge of drawing and painting, if sown during convalescence, should ripen when health is fully restored and continue to bear fruit throughout the years of normal life.

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#### Maritime Hospital Care Plan Given Blue Cross Recognition

Although in operation only since last June, the Maritime Hospital Service Association's Plan for Hospital Care has been given Blue Cross recognition by the Hospital Service Plan Commission of the A.H.A. Word of this action was received by Miss Ruth C. Wilson, Executive Director of the Plan from Dr. C. Rufus Rorem, Director of the Hospital Service Plan Commission.

The Maritime Plan for Hospital Care is now the fourth plan in Canada to be given this status and the 78th on the continent. Sixteen hospitals in New Brunswick, 12 in Nova Scotia and 3 in Prince Edward Island are members of the Plan. It has approximately 20,000 participants.

* * *

We understand that the new Plan in British Columbia is being considered favourably for Blue Cross recognition.

* * *

#### Added Benefits Provided Under Ontario Hospital Plan

Effective February 15th, 1944, the Plan for Hospital Care in Ontario increased the period of time for which benefits would be paid. Ten additional days of benefits have been added during the first year of membership and five additional days for each year of continuous participation of the subscriber or dependent in the Plan for Hospital Care up to a maximum of 51 days. The schedule of benefits is as follows:

31 days' care during 1st year
36 days' care during 2nd year
41 days' care during 3rd year
46 days' care during 4th year
51 days' care during 5th year.

### Here and There

*(Concluded from page 54)*

navel which must on that day, I suppose, make Oscar liable to be mistaken for Adam who was, presumably, created without that decoration.

I have transplanted belly buttons in great number since Oscar's time, with growing proficiency and increasing success. But I have always been careful in removing the dressings. And the memory of Oscar has checked me more than once when I have been tempted to make a proud triumphant flourish. Meekness is a good quality to cultivate whether or not it inherits the earth!

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**Extra Food for Convalescents**

A patient should be allowed 21 consecutive days in a hospital before he is required to surrender his ration book to the institution, according to a memorandum submitted by the American Hospital Association's Wartime Service Bureau to the Administrator, Office of Price Administration in Washington. "When a patient leaves the hospital as a convalescent, he still needs dietary supplement, and any savings there may be in the War Ration Book up to 21 days should be allowed the patient for this purpose."

This arrangement would also assist in reducing the administrative difficulties encountered in hospitals in keeping track of these ration books. This suggestion has been endorsed by the sub-committee on Medical Food Requirements of the National Research Council and also by the joint committee of the three national hospital associations.

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Army doctors have been attending civilian patients. It must be strange at first to maintain a soothing bedside manner and listen to 'flu symptoms described in detail and then not prescribe medicine and duty.—*Punch.*

**25 Bed Hospital Opened at Ste. Agathe**

The Hopital de la Providence at Ste Agathe, Quebec, officially opened its doors on January 25th. The hospital is a 25-bed, three-storey structure. It will be in charge of Sister Therese de St. Sacrement. The first floor is made up of an office, reception room, private rooms for patients, a modern kitchen, staff dining room, laundry and furnace rooms. On the second floor are private, semi-private, three and four bed wards. There is also a children's room and a nursery, a modern x-ray room, laboratory and emergency operating room. The third floor houses the sleeping quarters for the sisters and a small chapel.

## Coming Conventions

**March 15—American College of Surgeons War Session (Ontario), Royal York, Toronto.**
**March 17—A.C.S. War Session (Quebec, the Maritimes and Newfoundland), Mount Royal Hotel, Montreal.**
**April 18—A.C.S. War Session (B. C. and Alberta), Hotel Vancouver, Vancouver.**
**May 1-6—Institute for Administration (Nursing), U. of Man., Winnipeg.**
**May 21-26—Catholic Hospital Association, U.S. and Can., St. Louis, Mo.**
**May 22-26—Canadian Medical Association, Royal York Hotel, Toronto.**
**September—American Hospital Association, Chicago, Ill.**
**October 18-20—Ontario Hospital Association, Royal York Hotel, Toronto.**

## WANT ADVERTISEMENTS

*Advertisements in this department, up to 50 words, set in single column, $1.50 per insertion. If set in box, single column, $2.00 per insertion.*

**RESIDENT ANAESTHETIST WANTED**

for 450 bed general hospital. Applicants to state qualifications in detail and slary expected. Apply Superintendent, Saint John General Hospital, Saint John, N.B.

**DIETITIAN WANTED**

An experienced Head Dietitian for a 300-bed general hospital in the Maritimes. Apply to Box 1236, "The Canadian Hospital", 57 Bloor Street W., Toronto, stating qualifications, references and salary expected.

**SUPERINTENDENT OF NURSES**

The Winnipeg General Hospital (650 beds) will receive applications for the position of Superintendent of Nurses and Director of the School of Nursing (enrolment over 200). Salary open.

Applicants will please state age, educational qualifications and experience and submit names for reference and any other credentials desired.

Address applications to "The Superintendent, Winnipeg General Hospital, Winnipeg, Man.".

**WANTED**

**SUPERINTENDENT OF NURSES**

**for Regina General Hospital.**

● **Apply to: C. C. Gibson, Supt., stating age, qualification, experience and salary required.**

### Anaesthesia

*(Concluded from page 45)*

laryngo-spasm requires the same treatment. When the prone position —a posture seriously handicapping an anaesthetized individual—must be used, the lightest possible level of anaesthesia should be maintained, so as to preserve intercostal muscle activity. The air-way must be adequate, to which end it is advisable to so posture the patient by means of sand-bags under the hip and shoulder that the head may be moved on the trunk. Intubation or at least an artificial air-way is always indicated in these instances. A partially-obstructed air-way endangers the patient's life on the table. Protracted under-oxygenization and the piling up in the blood of waste products such as carbon dioxide may endanger his life in the post-operative period. When there are signs of circulatory failure, as is common in long operations, supportive measures such as the administration of blood or blood substitutes should be instituted, preferably before the need is urgent.

Large hospitals and many of the smaller units are equipped with carbon dioxide absorption types of anaesthetic apparatus. It need scarcely be asserted that no physician should make use of these machines without first having acquired experience under expert supervision. Nor should he use the newer anaesthetics except in similar circumstances. These are valuable to the trained anaesthetist but are dangerous in the hands of the uninitiated. Those not too familiar with these modern appliances are much more likely than the expert to supply a mixture to the patient inadequate in oxygen. In these circumstances the same train of events ensues as in the case of inadequate air-way in open methods. The colour of the patient is an ever-present guide. The axiom postulated in the early days of anaesthesia that "a pink patient never dies" is still good.

The depressant anaesthetics, chloroform and ethyl chloride, besides being subject to the complications just described, may cause concern to the anaesthetist because of circulatory effects peculiar to these agents. With chloroform syncope may occur early in the administration with but little warning, particularly following a severe surgical stimulus. Ethyl chloride, while less dangerous, should be watched carefully for cardiac depression. Pallor, shallow respiration and slowing of the pulse are signs calling for a temporary (at least) withdrawal of the anaesthetic. Special indications should be present when these agents are employed.

**(To be concluded in our April issue. Part II will deal with the Non-Volatile Agents and discuss spinal, intravenous and other forms of anaesthesia.)**

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### Women's Auxiliary

*(Concluded from page 39)*

meeting which brought a most gratifying response, both in attendance and in interest. The superintendent of the hospital and the superintendent of nurses addressed the gathering, giving detailed information as to what was expected of the volunteer and pointing out her relation to the hospital and its staff. I, in turn, on behalf of the Women's Auxiliary, called attention to the responsibility of the volunteer to live up to the dignity of the organization. The question period which followed was productive of much enlightenment to all.

Knowing that youth is excellently equipped for training to meet the emergency, our Juniors were organized into large groups and directed to evening home-nursing and first-aid courses under hospital staff instructors. The Canadian Red Cross Society became actively interested in bringing nursing relief to the hospitals and undertook the planning of V.A.D. courses. The Juniors who had obtained their home-nursing and first-aid certificates became eligible for the V.A.D. courses. Each young woman who is at present taking this course is pledged to eighty hours of service to the hospital in which she is being trained. While all this assistance is not a complete solution to the hospital nursing problem, certainly it is of tangible help and brings a measure of relief to the overtaxed nursing staff.

With an eye to the seasonal hospital needs, we have already enlisted a number of our Juniors to work on the hospital farm this summer. Every effort will be made to ensure that the maximum amount of produce will be harvested and preserved for the following winter.

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### Superintendent of Galt Hospital to Resign

Miss Mary Bliss, superintendent of the Galt Hospital, Galt, has resigned her position. The resignation is to become effective May 1st next. Miss Bliss came to the Galt Hospital in 1938. She is a graduate of the Royal Victoria Hospital at Montreal.

### Heads of Army Medical Services Named Acting Major-Generals

The Department of National Defence has announced the promotion to the rank of acting major-general of Brigadier G. B. Chisholm and Brigadier R. M. Luton. Major-General Chisholm has been director general of medical services at Defence Headquarters, Ottawa, since September, 1942, while major-general Luton has been at Canadian Military Headquarters in London, England, since October, 1939, first as senior medical officer, later as deputy director, medical services, and since February, 1941, as director.

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### Changed Status of Doctors

This advertisement appeared in a paper of the last century: "Wanted, for a family who have bad health, a sober steady person in the capacity of doctor, surgeon, apothecary and man-midwife. He must occasionally act as butler, and dress hair and wigs. He will be required, sometimes, to read prayers and to preach a sermon every Sunday. A good salary will be given".

—*"Hospital and Nursing Home Management."*

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**MARCH, 1944**



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